Iowa Medicaid Enterprise State Medicaid HIT Plan 2011

Version 2.1

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Change History

Date:	Changed By:	Changes:	Version:
09/08/2010	Jody Holmes Kelly Peiper Dane Pelfrey	Completed version 1.0 for submission to CMS	1.0
11/08/2010	Kelly Peiper Dane Pelfrey	Updated SMHP per Appendix Y - CMS SHMP Approval letter dated Oct 12, 2010 – Enclosures A & B	1.1
7/14/2011	Jody Holmes Kelly Peiper	✓ The Medicaid enrollment numbers and graphs have been updated. ✓ Strategic Planning section has been updated to reflect current status. . ✓ HIE Background has been updated to reflect ONC grant. ✓ Update on the Regional Extension Center progress. ✓ Section A has been updated to reflect the most recent assessment information. ✓ A section was added on the Community College Consortium. ✓ Section B was updated to reflect current information from additional planning for the Health Information Exchange by the stakeholder group. ✓ Section C has been updated to note the Iowa progress on the EHR incentive program. ✓ Section C now includes lessons learned. ✓ Section C process flows have been updated to reflect changes made to the process following implementation. ✓ Section D has been modified to identify changes to the pre-payment audit strategy. ✓ The section E roadmap has been updated to reflect new timelines, and notes which tasks have been completed. Each section has been reviewed and a status update note added to reflect progress on the goals and action items. The tables with specific timelines have been	2.0

		updated to reflect the shift in deliverable timeframes. ✓ Appendix. The sections from the Iowa e-Health strategic and operational plan have been removed. The updated plan can be reviewed at www.iowaehealth.org ✓ The project abstract for the Immunization and lab grants have been removed. ✓ The hospital calculator has been updated. ✓ The Iowa Administrative Code rules section has been updated to reflect the current rules. ✓ The provider agreement has been included as appendix F, including the PA addendum. ✓ Appendix G has been added to show the providers who have expressed interest in participating in the HIE, by provider type. ✓ Appendix H has been added to show the questions for Meaningful Use attestation.	
9/19/2011	Jody Holmes	✓ Modify Appendix F, to clarify language in sections II and IV	2.1

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Iowa Medicaid Enterprise State Health Information Technology Plan

Document Purpose

The Iowa Medicaid Enterprise (IME) created this updated State Medicaid Health Information Technology Plan (SMHP) as a deliverable to the Centers for Medicare and Medicaid Services (CMS) to continue operation of Iowa's electronic health record (EHR) incentive payment program. The updated SMHP describes how IME will continue to administer the program and enhance the program for Year Two incentives, as authorized under section 4201 of the American Reinvestment and Recovery Act (ARRA). The SMHP also outlines the Health Information Technology (HIT) initiatives the IME believes will encourage the adoption and meaningful use of certified EHR technology. The IME's goal is to use the SMHP as a tool to improve the quality of healthcare our members receive through the exchange of health care information.

This SMHP also serves as the IME's strategic Health Information Technology (HIT) planning document. The IME expects that medical advances, HIT advances, federal and state legislation, and provider needs will evolve, therefore, the IME will continue to revise the SMHP on an annual basis to show a rolling five (5) year vision of HIT needs within Iowa. This annual revision cycle aligns the needs of the IME's members, provider network, and HIT investments.

The IME recognizes that the funding of the individual projects and technologies within this document may come from different sources – Medicaid Management Information System (MMIS) Funding, HITECH Funding, State Funding Grants, etc. Funding for individual projects will be determined as part of the project planning and kickoff activities.

Key Stakeholders

Jennifer Vermeer, Iowa Medicaid Director

Iowa Medicaid Enterprise Policy and Contracting Staff

IME Members

IME Providers

Audience

Centers for Medicare and Medicaid Services (CMS)

Iowa e-Health - Iowa Department of Public Health (IDPH)

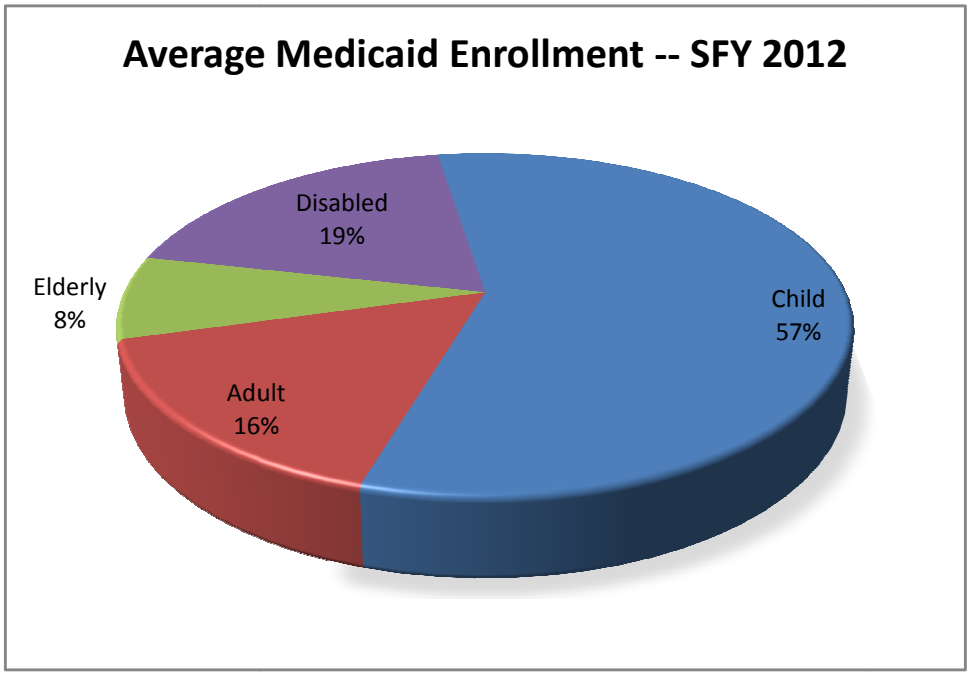
Office of Health Information Technology (ONC)

Iowa Medicaid Enterprise – Background

Iowa Medicaid Program

Medicaid is an entitlement program designed to provide medical care to low-income individuals who are aged, blind, or disabled, pregnant, under 21 years of age, or members of a family with dependent children. The program was authorized under Title XIX of the Social Security Act of 1965. The Medicaid program is funded jointly by the state and federal governments.

The Iowa Department of Human Services provided coverage to more than 618,000 individuals in SFY 2011 through full and limited benefit programs, including 1115 waivers and S-CHIP. This is over 19% of Iowa's population. The Medicaid population consists of four general categories: and is projected to serve the following in SFY 2012:



Average monthly enrollment in Medicaid by enrollment category

- 228,407 children
- 64,152 low-income parents and adults
- 76,047 persons with disabilities
- 31,451 elderly persons

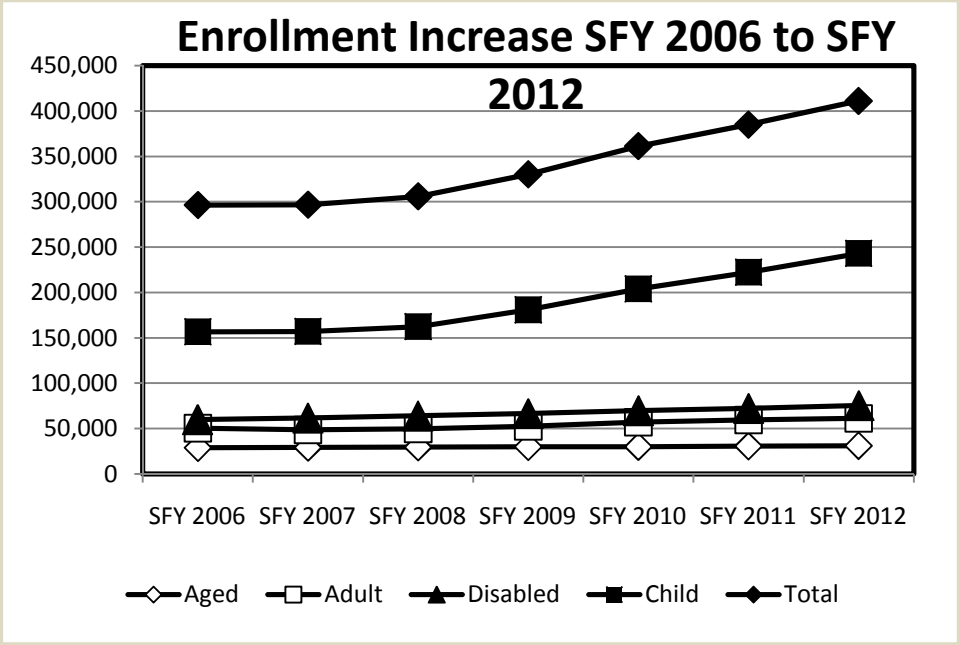
To be eligible for Medicaid, individuals must not only be low-income, they must also fall into one of the federally mandated categories: children, frail elderly, disabled persons, pregnant women, or very low-income parents.

This leaves many single persons and couples without dependent children ineligible for Medicaid, even if they have no income. With the implementation of the Affordable Care Act (ACA), the IME expects this population to be covered, thereby increasing the Medicaid rolls by 100,000-200,000 individuals.

Several eligibility groups within Medicaid (included in the figures above) receive a different level of benefits than the 'full-benefit' Medicaid program. These groups typically have higher income and the benefits are targeted to specific populations. These eligibility groups may require a premium and have limited benefits.

- QMB - For persons who are Qualified Medicare Beneficiaries (QMB), Medicaid covers only the cost of Medicare premiums, deductibles, and co-payments.
- IowaCare – This program is an 1115 demonstration waiver and covers persons who do not fit one of the Medicaid 'categories' with incomes below 200% of the Federal Poverty Level. The covered services are limited to inpatient and outpatient hospital services, physician services, and limited dental and transportation services. In FY 2010 members had access to only two providers, the University of Iowa Hospitals and Clinics in Iowa City, and Broadlawns Medical Center in Des Moines. In SFY 2011, the IowaCare program provided coverage to 68,000 unique adults and expanded the provider coverage to include Federally Qualified Health Centers (FQHCs).
- Family Planning Waiver – This program is also an 1115 demonstration waiver and covers women who do not qualify for the regular Medicaid program, up to 200% of the Federal Poverty Level. Women in the Family Planning Waiver receive only family planning services. Iowa projected 31,334 women would receive these services in SFY 2011, but actual numbers exceeded 47,000.

Overall enrollment in Medicaid has been increasing each year since 1996. This growth increased significantly in SFY 2010. Enrollment increases for children, parents and the disabled were above historical averages, while elderly population growth remained stable. The largest growth since 1996 is for children. Since the beginning of SFY 2011, Medicaid enrollment increased by four percent (4%). The following table shows actual and projected enrollment growth for each category since SFY 2006.



The large growth in children is due both to the economic downturn and the State's policy efforts to expand coverage for children. Families have lost access to health coverage due to employers dropping their health coverage, unaffordable premiums, or the loss of employment. Iowa policymakers established a goal of covering all uninsured eligible children. Specifically, the Department was to cover more than 25,000 children in three years. The Iowa General Assembly and the Governor enacted a series of initiatives in 2009 (SF 389) designed to expand coverage and increase enrollment in Medicaid. These include:

- **Expanding eligibility to 300% of the Federal Poverty Level effective July 1, 2009.** Note: in the Medicaid program this only applied to infants less than one year of age; the rest of the expansion occurred in the ***hawk-i*** program (see ***hawk-i*** offer for more detail).
- **Presumptive Eligibility** – This change will allow children to receive services during the time their formal application is being processed. It will also allow families to initiate enrollment through qualified entities which include medical providers and other community organizations, rather than only through the local DHS office. This change began in March 2010.
- **Express Lane Eligibility –** This change streamlined eligibility for children whose families are already enrolled in food assistance, but are not enrolled in Medicaid. It began in September 2010.
- **Increased public awareness campaigns** about Medicaid to encourage families to apply.
- **SF 389-** also directs the Department to implement other policies to streamline application and enrollment processes.

In 2010, 28,529 children were enrolled in either Medicaid or CHIP. This exceeded the original goal of covering 25,000 in three years.

Of the 2,375,555 insured lives in Iowa, Medicaid covers over 600,000 at some point during the

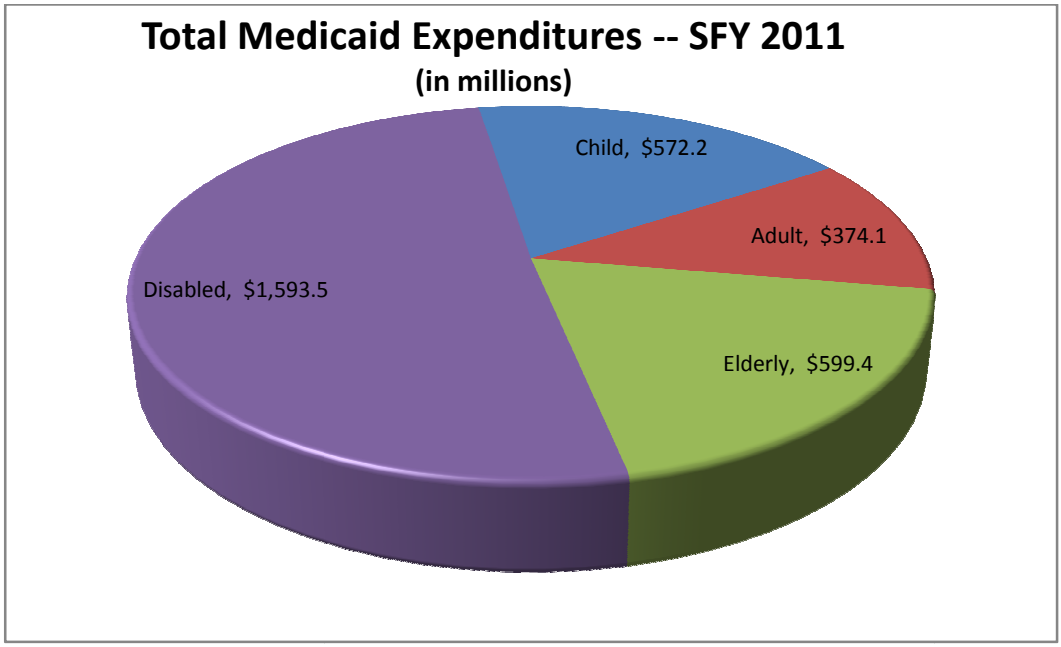
year, or approximately 25%.

Medicaid Coverage:

Iowa Medicaid pays for medically necessary health care services, including acute care services typically covered by any health insurance program. These include hospitalization, physician and advanced registered nurse practitioner (ARNP) services, dental care, emergency transportation by ambulance, laboratory, x-ray, and other services. The Medicaid program has a panel of more than 38,000 dedicated providers including hospitals, physicians, dentists, pharmacies, medical equipment providers, and many other health care providers of all types.

In addition, Medicaid provides coverage for long-term care services, such as nursing home care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and home and community based care that allows individuals to stay in their own homes or other small congregate settings. Long-term care services provided at home, such as home health, assistance with personal care, homemaking, and respite care allow individuals to avoid or delay institutional care.

The Medicaid programs serve Iowa's most vulnerable population, including children, disabled and the elderly. The cost of medical care for different Medicaid populations varies significantly. The average cost for each child in Medicaid is much lower than the average cost for each disabled or elderly person, since elderly and disabled individuals utilize more long-term care services. As shown in the charts above, although children make up 50% of the Medicaid population, they account for only 17% of total expenditures. This difference is true nationally as well. As noted above, there are a number of smaller programs within Medicaid that cover only a subset of the full-benefit package.



Typically five percent (5%) of Medicaid beneficiaries account for 57% of the Medicaid expenditures. These members with the most challenging health care needs are served in a fragmented and uncoordinated fee-for-service delivery system, with limited communication among providers. More than 50% of Medicaid beneficiaries with disabilities are diagnosed with mental illness. Behavioral health services are typically provided separately from physical health, with little or no coordination between the two delivery systems. Almost 20% of Medicaid members are dually enrolled in Medicare, increasing the complexity in providing coordinated care, often resulting in unnecessary emergency room utilization, hospitalizations, and nursing home placements.

For more information on Iowa Medicaid coverage refer to the following information:

http://www.ime.state.ia.us/Members/index.html

Medicaid members typically receive care from an array of providers who may be unaware of one another's treatment plans. This can result in duplication of services, inappropriate treatment and unnecessary prescriptions being prescribed. Many providers decline to serve the Medicaid population, saying they tend to have complicated medical problems, skip appointments, and have difficulty complying with their treatment plans.

Iowa Medicaid Enterprise

For the State of Iowa, the Iowa Medicaid Enterprise (IME) is the entity charged with administering the Medicaid Program. It exists under the Iowa Department of Human Services, and is staffed with approximately 36 state employees. The Department has implemented a model for the IME where nine professional services vendors work cooperatively with the Department staff to perform the Medicaid functions as described below. These functions are handled by one fiscal agent in many other states. Iowa has been successful with this unique model.

The IME established an environment and structures which enable the vendors to work together with Department policy and program staff to achieve common goals for the IME. Each vendor brings its specific best of breed expertise and knowledge to the IME. With this model, the IME functions much like a commercial health insurer - where the Department maintains ultimate authority and responsibility for the Medicaid program and hires those with expertise in specific domains.

The specific units within the IME:

- Provider Services
- Member Services
- Medical Services
- Pharmacy Medical Services
- Core MMIS (includes mailroom, imaging, workflow and claims administration)
- Program Integrity / Analysis and Provider Audits
- Revenue Collection / Estate Recovery Services
- Provider Cost Audit and Rate Setting
- Pharmacy Point-of-Sale
- Data Warehouse and Medical Systems

Iowa Medicaid Strategic Planning

The leadership staff at the IME is planning for multiple initiatives driven by state and federal regulations. These projects will impact, and be impacted, by HIT initiatives undertaken at the IME.

Project	Description	Timeline
HIPAA 5010	Modify MMIS to accept expanded standardized transactions. Gap analysis is completed.	January 2012
NCPDP D.0	HIPAA standard transaction changes including Medicaid pharmacy subrogation. Gap analysis is completed.	January 2012
ICD-10	Expansion of code sets from ICD-9 to ICD-10. Gap analysis is completed. Implementation strategies identified and selected.	October 2013
Eligibility System	Contract awarded. The new Medicaid eligibility system will be implemented by July 2013.	July 2013
Medical Home/Health Home	Iowa state legislation expanded the provider network and included a Medical Home component for this program. Planning includes the exchange of medical records between medical homes and specialty care.	Early 2012
MMIS / CORE services , POS procurement	The IME will evaluate the MMIS and Pharmacy POS contracts for professional services and systems and will write new RFPs for procurement.	July 2013
Budget Reductions	Iowa continues to experience budget constraints and staffing shortages. Hiring restrictions continue to keep the policy team understaffed. Technical resources are being expended to implement cost reducing measures.	July 2011

Project	Description	Timeline
Provider Electronic Enrollment / Re-Enrollment	The IME has an approved APD to expand its provider web portal. The IME is in the process of automating the enrollment and re-enrollment process.	January 2012
All Payer Claims Database	Iowa Medicaid will begin planning for an all-payer database in FY 2012.	FY 2012
Medical Systems Modernization	Iowa has an approved APD to modernize many of the systems that are not part of the CORE claims MMIS system, but are integral to the larger Medicaid Management Information Systems picture. A request for proposals was issued on June 6, 2011, with an award date of November 28, 2011. Full implementation of the new system is expected to occur in the fall of 2014.	August 2014

Iowa e-Health

In 2008, the Iowa Legislature enacted House File 2539, which established eleven advisory councils charged with making recommendations for health reform in Iowa. One of the eleven advisory councils is the e-Health Executive Committee and Advisory Council administered by the Iowa Department of Public Health (IDPH). The e-Health Executive Committee, with technical assistance from the e-Health Advisory Council and IDPH, is charged with the following:

a) Developing a statewide health information technology plan by July 1, 2009;
b) Identifying existing and potential health IT efforts, and integrating with state and national efforts to avoid incompatibility and duplication;
c) Coordinating public and private efforts to provide the network and communications backbone for health IT;
d) Promoting the use of telemedicine defined as the use of communications and information technology for the delivery of care, usually in ways not otherwise available in the patient's immediate environment;
e) Addressing workforce needs generated by increased use of health IT;
f) Recommending rules to be adopted in accordance with Iowa Code chapter 17A to implement all aspects of the plan and the network;
g) Coordinating, monitoring and evaluating the adoption, use, interoperability, and efficiencies of health IT in the state;
h) Seeking and applying for any federal or private funding to assist in implementation and support of the health IT system;
i) Identifying state laws and rules that present barriers to development of the health IT system.

With a broad health IT scope, the e-Health Executive Committee and Advisory Council first established the 2009 Iowa Health Information Technology Plan (the 2009 Plan) to serve as a preliminary strategic plan for Iowa e-Health. The 2009 Plan was approved by the e-Health

Executive Committee in June 2009 and the Iowa State Board of Health in July 2009. The 2009 Plan was subsequently submitted to the Iowa Legislature and included as an attachment to the Iowa application for the ARRA State HIE Cooperative Agreement Program available through the Office of the National Coordinator for Health IT (ONC). The 2009 Plan serves as a foundation for the development of the 2010 Iowa e-Health Strategic and Operational Plan. Iowa e-Health was awarded $8,375,000 over four years through a cooperative agreement with the Office of the National Coordinator for Health Information Technology. This funding will support the planning and implementation of the statewide HIE.

The 2010 Iowa e-Health Strategic and Operational Plan was created as a required deliverable of ONC's HIE Cooperative Agreement Program and will allow Iowa to access $8,375,000 of planning and implementation funds from 2010 to 2014. These ARRA funds will help Iowa e-Health execute the tasks and activities described in the Plan.

More information regarding Iowa e-Health and the Strategic and Operational Plan is available on the e-Health website: http://www.iowaehealth.org/. The plan was updated in March 2011 and can be found here: http://www.iowaehealth.org/documents/plans/64.pdf.

As a voting member of the Iowa e-Health Advisory Council, the IME is an active participant in all e-Health workgroups, and meets monthly with the Iowa Department of Public Health to coordinate efforts regarding Health Information Exchange, Health Information Technology, and the adoption of electronic health records.

Iowa HIT Regional Extension Center

The Iowa Foundation for Medical Care (IFMC) received the ONC grant to be the Health Information Technology Regional Extension Center (HIT REC) for Iowa. The REC is charged with assisting 1,200 primary care providers to improve care for their patients through the adoption and meaningful use of electronic health records. The REC provides technical assistance to primary care practices with ten or fewer professionals with prescriptive privileges. They also assist public and critical access hospitals (CAHs) providing primary care, and community and rural health centers that predominantly serve the uninsured, underinsured and underserved.

The REC has reached the half-way point toward its recruitment goals. As of July 13, 2011, the REC had filled the recruitment goal of 1200 Preferred Primary Care Physicians (PPCPs) and signed 52 CAHs for REC services. Momentum has picked up as a result of:

- Recent release of the first Medicare incentive payments.
- Continued payouts by Iowa Medicaid under their incentive program.
- Popularity of a silver model that allows practices to sign up with us for free.
- Dedication of the team in continuing to reach out to small practices.

All of these efforts combined with continued outreach at conferences, educational sessions and webinars have allowed the REC to achieve this milestone. More information on the Iowa HIT REC can be found on their website: http://www.iowahitrec.org/.

As a member of the advisory council for the HITREC, the IME collaborates closely with the HITREC to provide consistent communication to providers regarding EHR adoption, meaningful use, and available incentives. The IME and HITREC meet at least monthly to coordinate outreach efforts.

Section A: Iowa's "As-Is" HIT Landscape

Overview

Iowa's "As-Is" HIT landscape describes the level of HIT adoption by Iowa's health care providers as of June, 2011.

Provider EHR Adoption

In 2010, the IME conducted provider surveys in collaboration with Iowa e-Health to understand the barriers and utilization of EHR in Iowa. Surveys were developed and reviewed by e-Health workgroups and the IME staff. The IME promoted the surveys through meeting with professional organizations and utilizing our existing provider outreach processes.

Additional provider types, including home health care, long term care, laboratories, and pharmacies were included in the surveys and the following table summarizes their current HIT capabilities in Iowa.

Current Health Information Technology (HIT) Capabilities in Iowa	
Provider Type	**Electronic Health Record (EHR) Use:**
Provider Practices/Clinics (362 Respondents)	46% of Iowa's Provider Practices and Clinics use an Electronic Health Records (EHR) system.
Hospitals (93 Respondents)	10% of Iowa's Hospitals use an Electronic Health Record (EHR) for all patient records.
Home Health Care Agencies (72 Respondents)	35% of Iowa's Home Health Care Agencies use an Electronic Health Record (EHR) – urban and larger agencies are more likely to have access to this resource.
Long Term Care Facilities (90 Respondents)	25% of Iowa's Long Term Care Facilities use an Electronic Health Record (EHR) – larger systems are more likely to have access to this resource.
Pharmacies (282 Respondents)	27% of Iowa's Pharmacies have the ability to electronically transfer patient clinical information to patient providers.
Laboratory Facilities (127 Respondents)	35% of Iowa's Laboratory Facilities are able to share electronic data with other providers (physicians/hospitals).
Radiology Facilities (34 Respondents)	44% of Iowa's Radiology Facilities provide electronic reports or images to other providers.

Iowa providers see the timely availability of clinical data and increased workflow efficiencies as important benefits of using an EHR.

Value of Electronic Health Records (EHRs)	
Provider Type	**Benefits of EHR use include:**
Physicians	▪ Timely availability of clinical data ▪ Increased workflow efficiencies
Hospitals	▪ Timely availability of clinical data ▪ Increased workflow efficiencies
Home Health Care Agencies	▪ Timely availability of clinical data ▪ Less time to document patient care-related activities
Long Term Care Facilities	▪ Better communication with providers ▪ Improved patient safety (e.g., drug-related interactions or allergies)
Pharmacies	▪ Timely availability of clinical data ▪ Better communication with providers

Laboratory Facilities	▪ Timely availability of clinical data ▪ Less staff time to process test orders
Radiology Facilities	▪ Timely availability of clinical data ▪ Less staff time to process test orders

By connecting disparate health care systems across the continuum of care (e.g., clinic to pharmacy, hospital to long term care) via Iowa's Health Information Exchange (HIE), Iowa~~n~~ providers could have more timely access to their patient's most vital health information. This includes access to medication lists, allergy alerts, advanced directives, and to other pertinent health information.

Iowa providers place significant value on participation in a statewide HIE, especially for sharing summaries of patient care records (e.g., Continuity of Care Documents (CCD)), discharge summaries, and managing patient medications.

Value of Participation in a Health Information Exchange (HIE)	
Provider Type	**Valuable data for sharing through an HIE:**
Physicians Percentage interested in participating in an HIE not available.	▪ Summary of patient care records (e.g., CCD) ▪ Medication lists
Hospitals Percentage interested in participating in an HIE not available.	▪ Summary of patient care records (e.g., CCD) ▪ Managing patient care from one healthcare setting to another
Home Health Care Agencies 75% surveyed are interested in participating in an HIE	▪ Summary of patient care records (e.g., CCD) ▪ Discharge summary
Long Term Care Facilities 55% surveyed are interested in participating in an HIE	▪ Summary of patient care records (e.g., CCD) ▪ Managing patient care from one healthcare setting to another
Pharmacies 55% surveyed are interested in participating in an HIE	▪ Ability to request consultation for clinical advice from physicians or other providers ▪ Immunization status
Laboratory Facilities 63% surveyed are interested in participating in an HIE	▪ Lab results ▪ Reporting communicable diseases to the State Hygienic Laboratory and to the IDPH
Radiology Facilities 88% surveyed are interested in participating in an HIE	▪ Radiology results, images and image orders ▪ Patient allergies or contraindications

Iowa providers noted potential barriers to participation in Iowa's HIE, including increased costs for upgrading technology and potential liability issues if patient health information is compromised.

Potential Barriers to Participation in a Health Information Exchange (HIE)

Perceived Barriers	Physicians	Hospitals	Home Health Care	Long Term Care	Pharmacies	Labs	Radiology
Patient Privacy/Liability ▪ The Iowa e-Health proposed legislation includes protections for good faith use of the HIE.	X	X	X	X	X	X	X
Financial Issues/Cost ▪ Center for Medicare & Medicaid Services (CMS) provides Meaningful Use Incentives to providers to help cover costs of upgrading, adopting or implementing electronic health records.	X	X	X	X	X	X	X
Staffing and/or Workforce Issues ▪ The Midwest Community College HIT Consortium provides training to support electronic health records implementation through campus-based training and distance learning. DMACC and Kirkwood Community College are both part of this consortium.	X	X	X	X			

Overall, Health Information Technology capability and use varies among provider types and from rural to urban areas. However, Iowa providers place a significant amount of value on the increased ability to exchange electronic health information. It is widely accepted that the electronic exchange of health information can provide notable benefits, including enhanced patient care and reduced healthcare costs.

The IME is currently collecting results from a follow-up survey to Medicaid providers to gauge their adoption of EHRs and their awareness of the incentive program. While approximately 1,800 providers have already registered for both the Medicare and Medicaid incentive programs, the IME continues to remind providers of the availability of incentives and document barriers to provider adoption. The results of this survey will be compared to those taken in 2010 to measure the EHR adoption rates.

EHR Adoption - Hospital

In 2009, 85% of Iowa Hospitals were using some form of electronic health record. However, only 11% of the 85% reported that they "relied entirely on an electronic health record system." This indicates there is a significant effort needed to move hospitals towards achieving meaningful use of EHRs.

The major barrier to implementation is the capital to purchase and implement systems (65% of respondents). Additional barriers include ongoing cost to maintain the system, resistance from physicians, and finding an EHR that meets the hospital's needs.

The IME visited two hospitals, University of Iowa Hospitals and Broadlawns Medical Center, Iowa Medicaid's two largest member care providers, to better understand their current use of EHR technology and future HIT plans.

The University of Iowa Hospitals and Clinics (UIHC) is a strong advocate for EHR, providing leadership on the Iowa e-Health council. The UIHC implemented EPIC's EHR application into its hospital and physician clinics. EPIC is currently used for clinical support, but not used for administrative purposes such as scheduling or billing. Instead, the UIHC utilizes a separate practice management system for scheduling and a separate billing system. Both

systems are connected to EPIC. The UIHC continues to enhance the EPIC application with clinical decision support and specialty modules.

The IME and the UIHC held discussions regarding the needs for pediatric care for Iowa's Medicaid and IowaCare children's populations. The IME and the UIHC explored possibilities for the expansion of EPIC's care management module for coordination of services to children with special needs. Discussions also included the possibility of the UIHC providing EPIC EHR hosting services for Critical Access Hospitals to further improve Iowa's EHR adoption curve. As the UIHC provides specialty care for many Medicaid patients, discussions continue on how best to exchange information with primary care clinics and hospitals, especially for IowaCare members.

Broadlawns Medical Center is another leader in the adoption of EHR in Iowa. Broadlawns uses a combination of Meditech and LSS Data systems. Broadlawns moved rapidly to EHR Level 6 HIMSS adoption. Broadlawns experienced a marked improvement in claims processing and cash flow management from their EHR implementation.

As a key primary care provider to the IowaCare population, Broadlawns is active in promoting the electronic sharing of patient records between primary care and specialty care providers, specifically the UIHC. In late 2010, the UIHC and Broadlawns began exchanging patient information through continuity of care documents via a secured FTP site. This pilot showed the value of automated exchange of electronic records for both the patient and the practice.

The IME looks to the UIHC and Broadlawns to advocate EHR best practices, lessons learned, and Meaningful Use Version 2 & 3 through leadership throughout the next decade.

EHR Adoption – Long Term Care

Costs associated with Long Term Care (LTC) are a significant portion of the IME's annual expenses. The IME will continue to research the value of HIT within the Long Term Care setting. The IME continues to meet with several organizations within the Iowa Department of Human Services to discuss EHR Incentives available to their eligible providers, and documenting their HIT needs.

As the EHR/HIE/HIT environment continues to mature, Iowa's SMHP will be revised to reflect the needs of the LTC community, specifically in relation to EHR/HIE adoption and sharing of continuity of care and discharge instructions between providers.

Behavioral Health – Mental Health – Substance Abuse

Iowa Medicaid participated in the Substance Abuse Mental Health Services Administration (SAMHSA) sponsored conference on the use of Health Information Technology for Behavioral Health, Mental Health and Substance Abuse. This conference was the beginning of the dialog to determine how state efforts can best be aligned for these provider and population groups.

Federally Qualified Health Centers

Iowa's health center controlled network, INConcertCare, Inc, received an EMR implementation grant from Health Resource and Services Administration (HRSA). The grant, totaling over $1.3 million, along with a variety of other funding sources, is helping fund implementation of GE Centricity EMR in seven Federally Qualified Health Centers (FQHCs) in Iowa and one in Nebraska. Next Gen, and EHS EHR systems have been selected for implementation within individual FQHC locations. The grant's project period is September 1, 2009 – August 31, 2012.

Participating FQHCs in Iowa include:

- Proteus Migrant Health, Des Moines, Fort Dodge and Iowa City
- Primary Health Care, Des Moines and Marshalltown
- Peoples Community Health Clinic, Waterloo and Clarksville
- Crescent Community Health Center, Dubuque
- Community Health Center of Fort Dodge, Fort Dodge
- River Hills Community Health Center, Ottumwa, Richland, and Centerville
- Siouxland Community Health Center, Sioux City

Currently, Siouxland Community Health Center in Sioux City, Iowa, is live with Centricity EMR. Peoples Community Health Clinic in Waterloo and Clarksville, and Primary Health Care in Des Moines and Marshalltown, will go live in the fall of 2011. All seven Iowa centers will be live by the conclusion of the grant in August 2012.

INConcertCare provides other services including dental clinical information systems to eight FQHC's and population health management software (registry) to 15 centers. All software applications, including e-mail, are served up out of a data center located in Davenport, IA.

INConcertCare has executed a teaming agreement with the Regional Extension Center and participates in the Iowa Health Systems (Health Net Connect) FCC connectivity project. This connectivity will provide for up to 160 meg connectivity for the exchange of EMR data through the Statewide Health Information Exchange.

Veterans Administration & Indian Health Services

Within Iowa, the Veterans Administration (VA) has Medical Centers in Des Moines and Iowa City, and 11 Community Based Outpatient Clinics. Every location is connected within the VA's infrastructure using VistA and Computerized Patient Record System (CPRS) to share clinical information both within state VA locations, and worldwide within the VA's infrastructure.

The IME contacted the Iowa tribes under the Indian Health Services umbrella and found that the Winnebago tribe utilizes the Resource and Patient Management System (RPMS) provided by Indian Health Services. The Ponca Tribe and Meskwaki Settlement have plans to utilize the RPMS in the future.

Provider Incentive Payments

The IME's provider outreach efforts on the EHR incentive requirements and path to payment have been extensive. The IME has participated in presentations at Critical Access Hospital Meetings, Iowa Hospital Association Meetings, Iowa e-health Seminars, Iowa Medical Group Management Association, and at Medicaid Provider annual training seminars. Additionally EHR incentive information has also been shared through the IME's provider portal, through IME informational letters, and through several provider webinars.

The table below describes the number of participants the IME estimates becoming eligible for EHR Incentives:

Provider Type	No. of Providers	% Eligible	No. Eligible
Eligible Professionals			
Physician MD	7047	10%	705
Physician DO	1481	10%	148
Nurse Practitioner	813	10%	81
Dentist	1254	10%	125
Certified Nurse Midwife	41	10%	4
Total			**1063**
Acute Care Hospitals	37	100%	37
Children's Hospitals	0	0	0
Critical Access Hospitals	82	90%	72
Total			**109**

- Note – Physician Assistants (PAs) are not currently tracked as a separate provider type within the IME's MMIS system. The IME estimates that up to 50 PA's may become eligible for EHR Incentive

Based on our outreach efforts, the IME has received feedback that most Acute Care and Critical Access Hospitals will meet the 10% Medicaid patient/encounter thresholds. More difficult to predict is the number of Eligible Professionals who will meet 30% Medicaid patient/encounter thresholds (20% for pediatricians).

Informally, the IME estimated that approximately 10% of Eligible Professionals would meet their Medicaid encounter requirements. The IME then utilized claims information as a numerator and an average number of encounters per year as estimated by the American Academy of Family Physicians as a denominator. The IME determined a rough order of magnitude estimate that approximately 1,200 eligible providers will meet Medicaid encounter requirements. This rough order of magnitude is assumed accurate within a range of -50% to +200%.

As of June 20, 2011, the IME has paid out $5,524,130 in incentive payments to 110 EPs and 7 EHs. However, over 900 EPs have registered at the CMS Registration and Attestation site. The IME will continue its outreach efforts targeting these providers to determine their barriers and assist them in completing attestation in Iowa.

The IME projected that approximately half (50%) of the estimated 1,200 eligible providers would request EHR incentive payment during 2011 based on Iowa's EHR adoption percentages, and the required adoption of certified EHR technology. Of the 600 expected to attest in 2011, as of June 20, only 110 have done so. The IME continues to work with the providers and the Regional Extension Center to identify qualified providers and encourage them to attest. The IME still anticipates that during 2012-2016, an additional 10% of the remaining eligible providers will request EHR incentive payment each year.

The IME anticipates that these estimates will need to be revised based on actual requests within Iowa, and any available information on the EHR incentive request rates of other states.

Health Information Exchange

The IME and Iowa Department of Public Health (IDPH), as part of the Iowa e-Health EHR/HIE adoption initiative; have actively engaged Iowa's healthcare providers, insured citizens, and insurers. Due to the IME's expected use of HIE services and expected funding of HIE activities, the IME provides a strong presence on many of the workgroups and council sessions. The IME representatives on these groups focus on containing costs by improving the quality of care our members receive.

The current governance model for the Iowa e-Health initiative is best described as a government-led model with accountability to a multi-stakeholder, public-private e-Health Executive Committee and Advisory Council. The governance structure was established by a comprehensive health reform bill (2008 Iowa Acts, Chapter 1188). The legislation specified nine organizations be represented on the Executive Committee and eight organizations represented on the Advisory Council. Additional members of the Advisory Council were appointed by the Director of the Iowa Department of Public Health.

The nine voting members of the Executive Committee include: three chief information officers from the three largest private health care systems in the state; the chief information officer of the University of Iowa Hospitals and Clinics; a representative from a rural hospital selected by Iowa Hospital Association; a consumer member of the State Board of Health; a licensed practicing physician selected by the Iowa Medical Society; a licensed and practicing nurse selected by the Iowa Nurses Association; and an insurance carrier selected by the Federation of Iowa Insurers.

The 19 non-voting members of the Advisory Council include: a pharmacist; a licensed practicing physician; a consumer member of the State Board of Health; a member from the Iowa Medicare Quality Improvement Organization; the executive director of the Iowa Communications Network; a representative of the private telecommunications industry; a representative of the Iowa collaborative safety net provider network; a nurse informaticist; and eleven additional members representing key stakeholder groups, including the IME.

With the current government-led model, the IDPH provides accountability and transparency for planning and execution of project activities. The IDPH provides the personnel resources to coordinate planning activities and convene the e-Health

Executive Committee, Advisory Council, and multi-stakeholder workgroups. In addition to the e-Health Executive Committee and Advisory Council, the IDPH formed several workgroups to provide subject matter expertise (SME) for components of the planning process. Active workgroups include: 1) Health Information Exchange (HIE) Infrastructure and Networks; 2) Continuity of Care Document and Interoperable Electronic Health Records (EHR); 3) Safeguard Privacy and Security; 4) Governance and Finance; 5) Health IT Workforce and Education; and 6) Provider Adoption of EHRs.

The e-Health Executive Committee and Advisory Council began meeting in January 2009, and continues to meet monthly to engage in critical planning discussions, establish priorities, and execute project activities. Workgroups meet more frequently to further define, research, and carry out project activities.

In summary, the IME and the IDPH have brought together a cross section of Iowa's healthcare providers, insurance providers, government entities, and patient advocates to create an engaged executive board and active workgroups to promote provider adoption of EHR and HIE technology within Iowa.

More information on Iowa e-Health can be found on their website: http://www.iowaehealth.org/.

HIE Operations

Iowa e-Health issued a Request for Proposal for the creation of Iowa's statewide HIE. The IDPH issued a Notice of Intent to Award and recently executed the contract to the selected vendor. The IDPH plans to have the HIE infrastructure installed and pilot HIE implementations by winter of 2011.

HIE Structure

As described in the Iowa e-Health Strategic and Operational Plan (http://www.iowaehealth.org/documents/plans/64.pdf), Iowa brings significant assets to HIE adoption. Experience in the Adoption of EHRs, Infrastructure and Networks, Data Exchange, and Planning and Education as described within the plan will be utilized for HIE success. The Iowa Health Information Exchange will utilize a federated model with a centralized master patient index, record locator service, auditing, secure messaging, and translation services where appropriate. The structure will allow for point to point messaging, query/response, and publish/subscribe technology.

Iowa Medicaid plans to utilize the publish/subscribe technology to capture quality metrics for verification of meaningful use and medical home performance payments.

Multi-State/Border State HIEs

Iowa shares borders with Minnesota, Wisconsin, Illinois, Missouri, Nebraska, and South Dakota. Currently, the most prevalent HIE serving Iowans is Nebraska's Health Information Initiative (NeHII) HIE.

NeHII currently shares Continuity of Care Documentation, lab, image, and discharge instructions across a wide provider base in the Omaha, NE/Council Bluffs, IA, care

delivery area. More information on NeHII can be found on their website, http://www.nehii.org/.

NeHII currently provides HIE services to three western Iowa hospitals near Omaha, NE: Mercy Hospital in Council Bluffs, IA, Mercy Hospital in Corning, IA, and Community Memorial Hospital in Missouri Valley, IA.

The IME will continue to monitor HIE adoption within our border communities and expects that once Iowa's HIE is established, National Health Information Networking (NHIN) connectivity between HIEs will be prevalent for our border members and providers.

Broadband Access

During winter 2009/spring 2010, Iowa e-Health developed its ONC- required 2010 Iowa e-Health Strategic and Operational Plan. As Iowa's state designated entity, the IDPH was required to submit its strategic and operational plan to ONC to receive funding through the state HIE cooperative agreement program.

Goal 3 of the strategic and operational plan – Enable the Electronic Exchange of Health Information - discusses in depth the broadband access speeds found within Iowa practices. From the National Broadband plan, (Chart 3.2b), which recommends ten megabits (mb) per second or greater download access for the majority of Iowa's provider locations, currently only 18% of providers have access to 11mb download speeds. (Chart 3.2d)

The Iowa Communications Network "Bridging the Digital Divide for Iowa's Communities" award proposes to upgrade the existing 3,000-mile network to provide 10 Gbps-capable points of presence in each county, while enabling a system upgrade for as many as 1,000 community anchor institutions statewide to 1 Gbps Ethernet service. This infrastructure award of $16,230,118, which partners with Iowa Health System, will allow for a comprehensive statewide fiber network that serves public sector, private sector, and non-profit entities.

The Iowa Health System received $17,714,919 for their Iowa Healthcare Plus Broadband Extension Project. This project proposes to make significant upgrades to the health system's existing 3,200-mile fiber network that services over 200 healthcare facilities across the state and bolster their wireline capabilities with wireless technology.

The IME, as an active participant on Iowa's e-Health Council, will continue to support and leverage any and all grant opportunities available for the expansion of Iowa broadband network, per Strategy 3.2.1.

State Immunization & Public Health Surveillance

The Iowa State Immunization and Surveillance systems currently do not have the technical capacity to connect to the HIE or accept HL7 standard messages.

The Iowa Department of Public Health has applied for and been denied multiple grant applications for funding assistance to upgrade their system to meet the standards. Currently, Iowa is awaiting news regarding the Affordable Care Act (ACA) Funding

Announcement Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance grant announcements.

Connection to the Iowa Immunization Registry Information System (IRIS) has been identified as a priority service for the HIE by provider organizations. In the absence of the ACA funding, Iowa is seeking HITECH funding to support connecting IRIS to the Iowa e-Health systems.

The IDPH received $573,833 as part of the lab surveillance grant, approximately one-half the requested grant amount to begin the process of upgrading the Iowa Disease Surveillance system (IDSS) to accept electronic laboratory reporting. Iowa will be seeking HITECH funds to fill the $400,000 gap in funding needed to complete this project.

Upon completion of the upgrades to the Immunization and Iowa Disease Surveillance Systems, Iowa Medicaid will change the EHR incentive program rules to require providers to send data to these organizations as a component of the definition of meaningful use for Iowa Medicaid EHR incentive payments.

Member / Consumer

Iowa Medicaid began base lining our member's knowledge of EHR/HIE technologies during July 2010. The IME's member call center surveyed 100 members with the following results:

Question	Yes	No
Are you aware of electronic health records, and the ability to share your health information with other providers?	48	52
Do you support providers sharing your information electronically with the other providers who also treat you?	88	12
Is there any information you would not want shared?	10	90
Would you rather your information not be shared?	17	83

Based on this initial survey, the IME conducted a second survey to another 100 members through the member call centers with the following results:

Question	Yes	No
Are you aware of electronic health records, and the ability to share your health information with other providers?	48	52
Do you support providers sharing your information electronically with the other providers who also treat you?	86	14
Is there any information you would not want shared?	9	91

Question	Yes	No
Would you rather your information not be shared?	20	80
If Iowa Medicaid was able to make your personal health records available to you via a secure website, would you use/review that information?	85	15

In late May 2011, the IME administered the identical survey to an additional 150 random Medicaid members. Below are the results:

Question	Yes	No
Are you aware of electronic health records, and the ability to share your health information with other providers?	84	66
Do you support providers sharing your information electronically with the other providers who also treat you?	139	11
Is there any information you would not want shared?	16	134
Would you rather your information not be shared?	22	128
If Iowa Medicaid was able to make your personal health records available to you via a secure website, would you use/review that information?	126	24

Based on this sample, over the past year, the awareness of electronic records is up from 48% to 56% in the member population. There is also a slight increase in the percentage of members who support providers sharing information electronically: 88% to 93%. All other answers appear to be consistent with those collected a year ago.

The IME partnered with the IDPH and its vendor to develop a comprehensive patient/member focused communication plan. This plan is designed to serve all Iowans and provide information about the need for EHRs/HIE and address Iowan's privacy concerns.

The Iowa e-Health Communication Plan outlines the key communication, outreach and marketing strategies of Iowa e-Health for the upcoming year (State Fiscal Year 2012). During the upcoming year, communication activities will continue toward health care providers to instill an understanding of health information technology (health IT), Iowa e-Health, and the Iowa Health Information Exchange (HIE). Additionally, communication activities will be directed toward the general public to begin a long-term educational process of health IT, Iowa e-Health, and the Iowa HIE. The following approaches to reaching the general public include:

- General public page of the e-Health website (www.IowaeHealth.org)
- Video targeting the general public and loaded onto the e-Health website

- Print Advertising
- Media relations
- Blogs
- E-Newsletter
- Twitter
- Community outreach

Medicaid Information Technology Architecture

The Iowa Medicaid Management Information System (MMIS) is a mainframe application with primarily batch processing for claims and file updates. Noridan Administrative Services (NAS) is the Core MMIS contractor that manages the system, as well as the workflow management process system known as OnBase. The Division of Data Management (DDM) manages the separate data warehouse/decision support (DW/DS) system. Goold Health Systems, which is the pharmacy point-of-sale (POS) contractor, manages the prescription drug POS system that provides real-time processing for pharmacy claims.

The Iowa MMIS, based on Mainframe/Common Business Oriented Language (COBOL) architecture, is built around subsystems that organize and control the data files used to process claims and provide reports. The MMIS contains the eight standard subsystems: recipient, provider, claims, reference, management and administrative reporting (MAR), surveillance and utilization review (SUR), managed care and third party liability (TPL) as well as the supporting medically needy and early and periodic screening, diagnosis and treatment (EPSDT) subsystems.

The IME also supports ancillary systems for eligibility and enrollment, administering premium payments, Medicare buy-in, prior authorization of long term care and home and community based services, disease management, and an interactive provider portal. With the implementation of professional services contracts in July 2010, additional systems include data mining, predictive modeling, financial and health risk analysis, and program integrity analysis.

The IME feels that the interoperability of the Iowa HIE with many EHR systems based on HL7 standards also meet Medicaid Information Technology Architecture Infrastructure (MITA) intent. In conjunction with the HIE vendor, the IME will look to leverage current data needs with planned MMIS functionality to best achieve long term goals.

The IME also continues to leverage MITA intent in the development of Iowa's attestation system, as described in Sections C & D. The IME uses a service oriented architecture (SOA) to conduct transactions between the CMS registration and attestation site and Iowa's EHR Incentive Payment system.

Community College Consortium

Approximately 50,000 qualified health IT workers will be needed to meet the needs of hospitals and health care providers as they adopt electronic health records and connect to

health information exchanges. The Bureau of Labor Statistics, Department of Education, and independent studies estimate a workforce shortfall over the next five years. Iowa community colleges, Kirkwood Community College in Cedar Rapids (http://www.kirkwood.edu/hitconsortium) and Des Moines Area Community College in Des Moines (https://go.dmacc.edu/conteddesc/hit/Pages/welcome.aspx), are two of the 17 community colleges that make up the Midwest Community College HIT Consortium funded by the ONC. Both colleges offer the 6-month certificate program to address the workforce need. The programs offer training in the following roles:

- Practice workflow & information management redesign specialists
- Clinician/practitioner consultants
- Implementation support specialists
- Implementation managers
- Technical/software support staff
- EHR trainers

Instruction is delivered online and internship opportunities are available through Iowa's Regional Extension Center. From this program to date, the REC has had six interns. The REC provides job shadowing opportunities so that the students can experience a site visit to a clinic setting and/or hospital setting with an experienced EHR Advisor. The job shadow is typically 1-2 working days. The REC selects site visits that will expose the students to meaningful use and/or EHR implementation issues where actual assessments are completed, or workflow redesign is mapped out, or reports of findings from previous assessments are discussed with the local teams.

The partnership between the REC and the Workforce programs benefits both entities - the REC has the opportunity to meet potential future staff and the Workforce program benefits from seeing the REC staff firsthand. And of course the students benefit. As an example, one of the students who job shadowed with the Iowa REC finished the program and was hired by the Washington, DC REC.

Section B: Iowa's "To-Be" HIT Landscape

Overview

Iowa's "To-Be" HIT landscape describes the vision for health care improvement through the adoption and meaningful use of HIT by Iowa's health care providers.

IME- Five Year Goals

The IME established four primary goals for the next five years to maximize the quality and efficiency of the healthcare services our members receive.

1. Increase provider adoption of electronic health records and health information exchange
2. Improve administrative efficiencies and contain costs
3. Improve quality outcomes for members
4. Improve member wellness

The dramatic increase expected in the number of Medicaid members means the IME must make every effort to improve the efficiency of the services our providers deliver. The IME is committed to supporting healthy outcomes for its members, and efficient and effective payments to providers.

Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE)

Central to the IME's HIT strategy is the need for clinical information in electronic format. The IME will encourage Iowa's providers in gathering clinical information at the time of care through use of EHRs.

The IME supports EHR adoption through provider outreach, the administration of the EHR Incentive program, and use of EHR enabled processes within the IME. The IME's successful launch of the incentive payment program on January 3, 2011, is a key measure of success in supporting EHR adoption in the state.

Over 2010 and 2011, the IME met with several provider organizations reaching hundreds of providers directly, and many more providers via their organization. The IME discussed the provider and member benefits related to EHR and HIE adoption. As described throughout this document, the IME feels that EHR and HIE technology is proven to improve the quality of care received by our members. Decreased adverse events from medication interactions, improved efficiency of healthcare providers, increased access to continuity of care and discharge instructions yield more streamlined coordination of care across providers, as examples.

The IME works closely with IDPH and Iowa's HIT REC to coordinate our outreach efforts and message. Often the IME, IDPH, and HIT REC co-present information. The IME plans to continue these activities throughout the lifespan of the EHR incentive program and beyond.

Future outreach efforts will describe EHR adoption rates within Iowa, total dollars the IME providers have received in EHR Incentive payments, success stories from providers utilizing EHRs and HIEs, etc.

The table below establishes goals for the adoption and implementation of electronic health records for Iowa providers.

Group	**2011**	**2012**		**2013**		**2014**	
	Utilize Certified EHR	Utilize Certified EHR	Meaningful Use of EHR*	Utilize Certified EHR	Meaningful Use of EHR	Utilize Certified EHR	Meaningful Use of EHR
Hospitals	50% (2009)	60%	20%	70%	40%	80%	60%
Physicians	40%	50%	20%	60%	40%	70%	50%
Dentists	20%	30%	25%	40%	30%	50%	40%
Nurse Practitioners	40%	50%	20%	60%	40%	70%	50%
Certified Nurse Midwives	40%	50%	20%	60%	40%	70%	50%
FQHC-Rural Health Clinic PA	40%	50%	20%	60%	40%	70%	50%
Pharmacy	75%	80%	n/a	85%	n/a	90%	n/a
Lab	20%	25%	n/a	30%	n/a	40%	n/a
Imaging/Radiology	20%	25%	n/a	30%	n/a	40%	n/a
Home Health	10%	15%	n/a	20%	n/a	25%	n/a
Long Term Care Facilities	10%	15%	n/a	20%	n/a	25%	n/a
Behavioral Health	10%	15%	n/a	20%	n/a	25%	n/a

- Meaningful Use of EHR percentages are meant to represent the percentage of the entire group achieving Meaningful Use – not only the subgroup utilizing EHR.
- Meaningful Use Standards have not been established for Pharmacy, Lab, Imaging/Radiology, Home Health, Long Term Care, or Behavioral Health at time of writing.
- Note – Pharmacies, Labs, Imaging/Radiology Centers, Home Health, Long Term Care, and Behavioral health are not currently eligible for EHR incentive payments.

Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE), cont.

Objectives:

1.1 Providers will capture medical clinical information electronically and exchange the information with other providers.

1.1.1 Administer Medicaid EHR Incentive Payment Program.

1.1.2 Support Iowa's statewide Health Information Exchange.

1.1.3 Support the National Health Information Network (NHIN) connectivity model.

1.2 Identify providers who are not currently eligible for Medicaid incentive payments or HITREC assistance and determine the appropriate technical assistance and support required to help those providers access appropriate electronic clinical information or adopt EHRs and exchange health information.

Improve Administrative Efficiencies and Contain Costs

As Iowa's providers continue to adopt EHRs, the IME will research and implement methods for transmitting clinical information between the IME and providers in the most efficient manner.

Objectives:

2.1 Utilize the Health Information Exchange and EHRs where possible to provide information to providers.

2.2 Utilize the Health Information Exchange where possible to eliminate the need for mailing or faxing of medical information between providers and the IME.

2.3 Provide access to the Health Information Exchange for targeted providers where quality improvements yield cost reductions or containment for Medicaid.

Improve Quality Outcomes for Members

The IME believes that the continued use of EHR/HIE technology will improve the care members receive. More complete information at the time of care will decrease errors in care delivery and improve the overall care members receive.

Objectives:

3.1 Improve care transitions between provider settings.

a. Decrease hospital readmissions from Long Term Care Facilities. Provide Discharge Instructions and Continuity of Care information real-time from Hospitals to LTC via EHR & HIE adoption.

b. Decrease LTC readmissions from Home Health Services. Provide Discharge Instructions and Continuity of Care information real-time from LTC to Home Health Services via EHR & HIE adoption.

c. Support patient/home health collection of relevant vitals via HIE patient/home health portals.

3.2 Utilize Health Information Technology to expand the application of evidence based treatment.

3.3 Capture Quality Measures for monitoring provider performance.

a. Determine if correlations between quality measures and underserved populations exist.

Improve Member Wellness

Providing members with access to their clinical information and information on wellness/self care practices will improve member's wellness and decrease the need for treatment.

Objectives

4.1 Provide members with information regarding their personal health.

4.2 Provide Medicaid member's care teams with clinical information.

4.3 Provide members with wellness education.

4.4 Create a Medical Home model that promotes healthy outcomes and manages the member's chronic health conditions.

Medicaid Information Technology Architecture

At the end of FY 2015, the IME anticipates significant progress will be made towards the following goals:

1. Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards.

   Iowa anticipates a rapid increase in the ability to communicate the appropriate medical information between providers, providers and members, and providers and Medicaid.

2. Promote an environment that supports flexibility, adaptability, and rapid responses to changes in programs and technology.

   Iowa's eligibility, enrollment, and claims adjudication systems will be updated to utilize rules engines and service oriented architecture.

3. Promote an enterprise view that supports enabling technologies that are aligned with Medicaid business processes and technologies.

Iowa will continue to support the 'best of breed' utilization of tools. These tools will be appropriate to the business process requirements and integrate seamlessly with other systems, where appropriate.

4. Provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for health care management and program administration.

   With the addition of new data mining tools, Iowa anticipates an increased ability to apply health informatics to improve program management. As provider's adoption of electronic health records systems expands, we anticipate the ability to collect clinical data and quality metrics for improved analysis and decision support.

5. Provider performance measurement for accountability and planning.

   Performance measures will be available for establishing pay-for-performance initiatives, and best practices technical assistance for providers.

6. Coordination with public health and other partners, and integrated health outcomes within the Medicaid community.

EHR Incentive Program Administration

The EHR incentive payment process was successfully integrated within the existing business processes at the IME. The administration of the EHR incentive program is discussed in further detail in Sections C and D. As of June 20, Iowa has paid over $5.5 million in incentive dollars to 110 eligible professionals and 7 hospitals.

Iowa has enhanced its provider portal to collect additional information and attestation from providers applying for the incentives. Document management and workflow have been integrated into the existing Onbase system, and electronic documentation is used where possible. The IME uses the MMIS claims payment system to make the payments to providers.

In 2011, Iowa has focused on collecting data elements and items required for Adopt/ Implement/ Upgrade attestation. EHR Incentive workflow processes will be enhanced by 2012 to include collection of all necessary data element for tracking and verifying meaningful use.

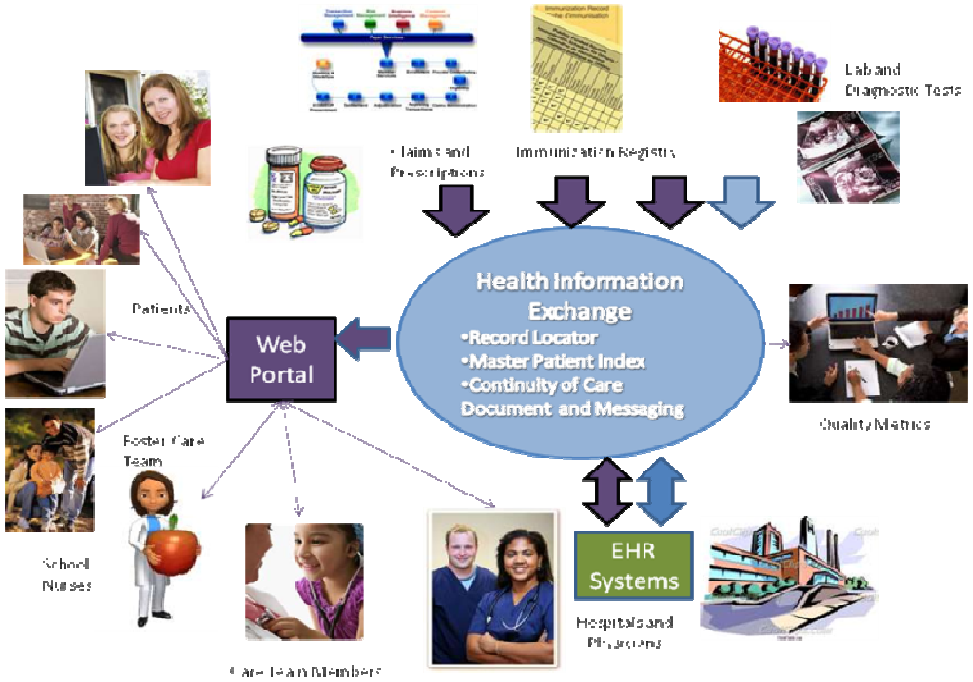
Although allowed for in the final rule, Iowa will not request that the four public-health related objectives be moved from the menu set of meaningful use measures to the core set of meaningful use measures in 2012. In 2013 or beyond, Iowa will again evaluate the need to collect the public health measures.

As allowed in the final rule, Iowa has determined that Hospital EHR incentive payments will be paid over three years. 40% of the total incentive paid in Year One, 40% in Year Two, and the remaining 20% in Year Three. This payment approach rewards hospitals for A/I/U, supports efforts to meet meaningful use, and increases the likelihood of maintaining meaningful use. Iowa considered balancing the payments across additional years, but acknowledges that the incentive will best be placed at the beginning of the transition to meaningful use.

The IME's provider portal will also be enhanced to survey providers regarding their EHR implementation and meaningful use status and future plans. This survey will be collected as part of provider re-enrollment and will allow Iowa to continue to monitor EHR adoption progress within the state, beyond those providers who are receiving incentives. Provider re-enrollment is currently slated to begin in January 2012.

Health Information Exchange

Iowa will have a sustainable health information exchange managed by Iowa e-Health, a division of the Iowa Department of Public Health. The Iowa e-Health board is appointed by the Iowa legislature and supported by the Iowa Department of Public Health.



The Iowa e-Health health information network will work in partnership with Iowa health care providers, payers, and consumers to build a sustainable infrastructure for the secure exchange of electronic health records. The service will be considered a public utility, and will be governed by state and federal laws with standards regarding interoperability, privacy and security.

The IME will continue to participate as a partner in this venture with IDPH, as described in Section E "Support HIE", ensuring that the needs of the Medicaid members and providers are met through this utility. The IME will build upon this model to continue to expand access to the appropriate members of the care team.

The IME believes the benefits of sharing information contained within EHRs via HIEs will improve the quality of care our members receive. Decreased impact of drug interactions, improved coordination of care across providers, and real time access to clinical information during emergency care are only a few of the benefits the IME is expecting from EHR & HIE adoption. The IME will provide funding support for the creation of a

state-wide HIE based upon a cost allocation model. Iowa e-Health has drafted a financial sustainability model that includes planned participation from providers and payers within the Iowa network. As of July 5, 2011, the financial model has been reviewed by the executive and advisory councils and is scheduled to be approved by the end of this month. The Iowa e-Health council is in the process of drafting signed agreements with early participants that include financial commitments and deliverable schedules.

The IME will also ensure that an option exists for the IME Member's care teams who may not need the full functionality of an EHR. Care team members who may need limited EHR/HIE functionality could include care coordinators, school nurses, foster care parents, parents, case workers, and others as appropriate.

Section C: Iowa's EHR Incentive Payment Program

Overview

This section describes the process(es) required for the Year Two administration of the incentive payment program, including capturing attestation for meaningful use and clinical quality measures.

EHR Incentive Payment Table – Estimated

This table reflects estimates for Medicaid EHR Incentive payments by provider type.

Provider Type	No. of Providers	% Eligible	Est. No. Eligible	2011 Request	2012 Request	2013 Request
Eligible Professionals						
Physician MD	7047	10%	705	350	420	490
Physician DO	1481	10%	148	75	83	90
Nurse Practitioner	813	10%	81	40	48	56
Dentist	1254	10%	125	63	70	77
Certified Nurse Midwife	41	10%	4	2	3	3
Physician Assistants practicing in an FQHC/RHC that is so led by a PA	0	unknown	50			
Total			**1133**	**530**	**624**	**716**
Acute Care Hospitals	37	100%	37	25	30	37
Children's Hospitals	0	0	0	0	0	0
Critical Access Hospitals	82	90%	72	40	60	72
Total			**109**	**65**	**90**	**109**

- Note – Physician Assistants (PAs) are not currently tracked as a separate provider type within the IME's MMIS system. The IME estimates that up to 50 PA's may become eligible for EHR Incentive

EHR Incentive Payment Table – Actual

Provider Type	No. of Providers	% Eligible	Est. No. Eligible	2011 Request[1]	2012 Request	2013 Request
Eligible Professionals						
Physician MD	7047	10%	705	78		
Physician DO	1481	10%	148			
Nurse Practitioner	813	10%	81	26		
Dentist	1254	10%	125	4		
Certified Nurse Midwife	41	10%	4	1		
Physician Assistants practicing in an FQHC/RHC that is so led by a PA	0	unknown	50	1		
Total				**110**		
Acute Care Hospitals	37	100%		7		
Critical Access Hospitals	82	90%				
Total				**7**		

Of the payments made to the 78 physicians, 10 were made to pediatricians qualifying with a Medicaid patient volume between 20% and 30%.

Outreach and Provider Support

The IME has implemented several communication mechanisms to educate providers on the incentive program. The primary methods of outreach include:

[1] As of June 20, 2011

Method	Implementation Date	Resource
Informational letters sent to all eligible provider types to complete the online questionnaire and indicate interest in the program	January 2010 April 2010 June 2010 September 2010 May 2011	http://www.ime.state.ia.us/Providers/Bulletins.html http://www.ime.state.ia.us/docs/938_RadiologyAssessment.pdf http://www.ime.state.ia.us/docs/1014_MedicaidEHRIncentivePaymentProgram.pdf
Collection of contact information for all interested providers	January 2010 - ongoing	Collected from providers responding to informational letters
One point of contact for providers to learn of incentive program	January 2010 - ongoing	Advertised to providers through informational letters
Educational webinars for providers	February 22 March 11 August 4 August 27 September 8 September 17 February 2011	Most recent posted at EHs: http://www.ime.state.ia.us/docs/Microsoft%20PowerPoint%20-%20Medicaid%20EH%20Registration..pdf EPs: http://www.ime.state.ia.us/docs/Microsoft%20PowerPoint%20-%20EP%20Registration..pdf

Method	Implementation Date	Resource
Presentations at professional organizations	February 2010 - present	Iowa Hospital Association IMGMA Rural HITECH Conference Iowa Regional Extension Center Annual e-Health Summit Linn County Medical Managers Iowa HIMSS Iowa Rural Health Association IANEPCA Critical Access Hospital Association Iowa Advocates for MH Recovery Conference Indian Health Services, Aberdeen and Billings Area MU Conference
Coordination with the Iowa Department of Public Health (IDPH) and presentations at e-Health Council meetings	January 2010 - present	http://www.iowaehealth.org/
Development of incentive program webpage	July 2010	http://www.ime.state.ia.us/Providers/EHRIncentives.html
Administration of online questionnaire regarding program readiness	April – present	**http://www.tfaforms.com/148942**

Method	Implementation Date	Resource
E-mails sent to interested providers to complete online questionnaire regarding EHR readiness	April - September 2010	
Incentive program module added to the annual provider training curriculum Informational letter sent to advertise HIT module	April – August June 2011	http://www.ime.state.ia.us/Providers/TrainingSchedule.html http://www.ime.state.ia.us/Providers/Bulletins.html
Targeted presentation at the annual provider training sessions	April – August 2010	

Since 2010 submission of the State Medicaid HIT Plan (SMHP), the IME has built out the website to include the following:

Method	Implementation Date
Instructions on how to apply for incentives	December 2010
Frequently Asked Questions document	May 2011
Copy of the final, approved SMHP	December 2010

Future outreach efforts include:

Method	Target Implementation Date
Educational materials to be included in new provider enrollment packets	July 2011
Webinars - including training on how to apply for the incentive program and Q and A sessions.	Ongoing
Information to be disseminated and collected during provider re-enrollment	January 2012
Informational letters to eligible providers advertising the go-live date	Ongoing
Additional targeted outreach (phone calls and e-mails) to providers appearing to meet the minimum patient threshold	Ongoing
Periodic announcements on remittance advice statements regarding the program	2011-2021
Presentations regarding the EHR incentive program and the planned strategic use of HIT at the IME Annual Training. Sixteen training sessions will be held around Iowa. Informational letters were sent to providers targeting eligible professional and hospitals.	June 2011 - August 2011

Iowa Annual e-Health Summit	August 11 and 12, 2011

During the implementation phase, the IME had continued to have a single point of contact, the incentive payment program coordinator, who answered provider questions regarding the incentive program. Since program launch, the ongoing level of provider support has required an additional one and a half FTE to handle the following aspects of the program:

- Continued provider outreach, including presentation of the HITE module at annual provider training
- Provider help line for answering basic provider questions, including technical assistance for the online tool
- Responding to provider e-mails to a dedicated incentive program e-mail box.
- Verification of provider eligibility and attestation review
- Approval of payments
- Assistance during appeals

The incentive payment program coordinator role offers additional guidance to the EHR staff and addresses unique provider questions or escalated issues, as well as interactions with CMS and the systems support staff at the CMS Registration and Attestation site. The IME continues to monitor the level of effort and will adjust staffing levels accordingly to adequately meet the demand. Audit functions, described in further detail in section D of this document, are assigned to the current staffing level in the program integrity unit.

Provider Incentive Payment Program Highlights

As planned, the provider incentive payment program launched on January 3, 2011. To prepare for the launch, the month of December was spent on the following activities:

- Finalizing systems testing, including interface testing with the CMS Registration and Attestation Site.
- Conducting significant outreach activities, including lining up the “pilot providers”, or those we expected to be among the first to attest and holding webinars on the registration and attestation process.
- Completing all administrative supports in the process, including finalizing the administrative rule, developing denial forms and the developing the Provider EHR Agreement, in conjunction with the Iowa Attorney General’s office.

In the first month of operations, over 800 EPs had registered at the CMS Registration and Attestations site, but we had only about 10 EPs complete Iowa’s attestation. After researching the issue, we realized many providers from one clinic had been registered for the Medicaid incentive program, but their qualifications had not yet been determined. This large discrepancy continues, with over 900 EPs registered at the CMS site, but only 110 having actually completed attestation in Iowa. The IME has reached out to those providers to resolve barriers to attestation.

The average length of time from the completion of provider attestation to the time of payment is 15 business days. However, that number includes several outliers whose payments were delayed due to interface issues with the CMS Registration and Attestation site. By removing those outliers (the longest of which was 46 days), the average number of days from attestation to payment is reduced to six.

IME has denied nine applications for payment:

- Five EPs failed to meet patient volume requirements.
- One hospital used wrong fiscal year (later re-attested and was paid).
- One hospital registered with their provider group NPI instead of the hospital NPI.
- One physician was not enrolled in Iowa Medicaid.
- One EP used a 90-day timeframe from 2011 instead of the previous calendar year.

Lessons Learned

As an early launcher, The IME has many lessons learned and has identified numerous invalid assumptions. The IME has been sharing these on a regular basis at conferences, CMS communities of practice, and through phone calls with other states. The lessons learned are divided into two categories: those learned for providers and those for states. We share the provider lessons to help educate other states on what to look out for and to assist in their educational efforts to their providers.

Providers

- Hospitals need an **online** PECOS account. This one came up early as our pilot hospital was unable to proceed at the CMS R&A site because they didn't have their PECOS account setup for online access. Obtaining the online account took several weeks and significantly delayed payment to this hospital.
- Hospitals need to know which fiscal year to use for what purpose. There is much confusion on the difference between payment year and which fiscal year to use for patient volume and when supplying the figures needed for the hospital incentive calculation. The final rule leaves several areas of discretion to states on determining what fiscal year to use for what purpose and states must be clear on communicating these differences to providers.
- Have your NPPES login information handy. Because it has been several years since providers obtained their NPI, they may no longer have the NPPES login credentials necessary to access the CMS R&A site.
- Know your CMS EHR certification number. Early on there was much confusion between this number and the ONC certification number. Iowa had several providers who had an ONC module certified, but not a complete EHR. Removal of the ONC number from the CHPL has reduced this confusion.
- Use the correct NPI. Iowa had one hospital register as a hospital, but used their clinic NPI.
- Think carefully if you are going to use clinic level or individual level approach. Providers need to understand that whichever approach they use applies to all EPs in the clinic. Iowa had a group of EPs using the individual level, but they applied at different times.

The last EP to apply realized he didn't meet the patient volume requirement on his own, but would have if they had used the clinic level approach.

- Know your 90-day period and use the correct year. Despite clear guidance on this, Iowa continues to receive applications in which the providers use a 90-day period from 2011. A system edit could help alleviate this issue.
- Work with a vendor to get proof of volume. Providers report some difficulty in determining how to calculate patient volume. Iowa encourages them to talk to their vendors to help determine this figure.
- Make sure the EPs are enrolled if they are supposed to be! This is an issue requiring an understanding of your state's Medicaid enrollment rules. Iowa has some provider types who cannot enroll (i.e., physician assistants) and there are some providers who are not required to enroll (such as nurse practitioners working under physician-supervision, or EPs practicing in an FQHC or RHC). When Iowa receives an application from an EP whose NPI is not in the MMIS, EHR staff must research if the EP is in compliance with the IME's enrollment rules.

State Medicaid Agency

An ongoing challenge for the IME has been identifying all of the state options and making sure that these options are included in the State administrative rule. This list continues to evolve and affect our rule, which has already been amended once. Our current list of state options includes:

- Pediatrician definition
- Clinic definition
- Which fiscal year to use for hospital patient volume
- Timeframe for average length of patient stay
- Payment methodology for hospitals

Other administrative application processing issues are:

- Providers who are not enrolled in the Medicaid program. As stated earlier, the IME does not require certain providers to be enrolled even though they are treating Medicaid patients. A step in the IME provider enrollment process is for providers to sign the Provider Agreement. The IME making payments to EPs who are not under the obligations of the current provider agreement caused the IME to develop a separate agreement specifically for those EPs who were not under the general provider agreement. A copy of this additional agreement is included in Appendix H.
- An assumption in the planning phase was that the IME would be able to validate the numerator in the patient volume calculation. It quickly became apparent that we would need to rely on provider records, even for the numerator. This is the case most frequently identified for the OB providers who submit one claim for the bundled services at the end of a pregnancy and for providers who bill as a clinic, such as the FQHC, RHC and family planning clinics. This is another example where EPs who are not enrolled in the Medicaid program become more problematic.
- Validating the NPI/tax id (TIN) combination is challenging for some applications. Simply checking the MMIS is not accurate when providers who are enrolled, and therefore bill, with numbers different from those they received from, National Plan and Provider Enumeration System (NPPES). When the NPI was implemented, providers self-

reported their NPI to the IME. The IME developed a cross-walk solution to identify the correct legacy number. Providers were able to use either their individual NPI or an organizational NPI in a number of combinations with an organizational TIN or even a social security number. When the IME is unable to validate a TIN/NPI combination on the MMIS, staff access the NPPES website for validation, in addition to contacting the provider for any other supporting documentation that might be necessary.

Business Process Flows

In designing the incentive payment process, the IME developed high-level process flows to serve as a visual point of reference. Process narratives follow the flows along with additional details on the specific steps involved in each phase.

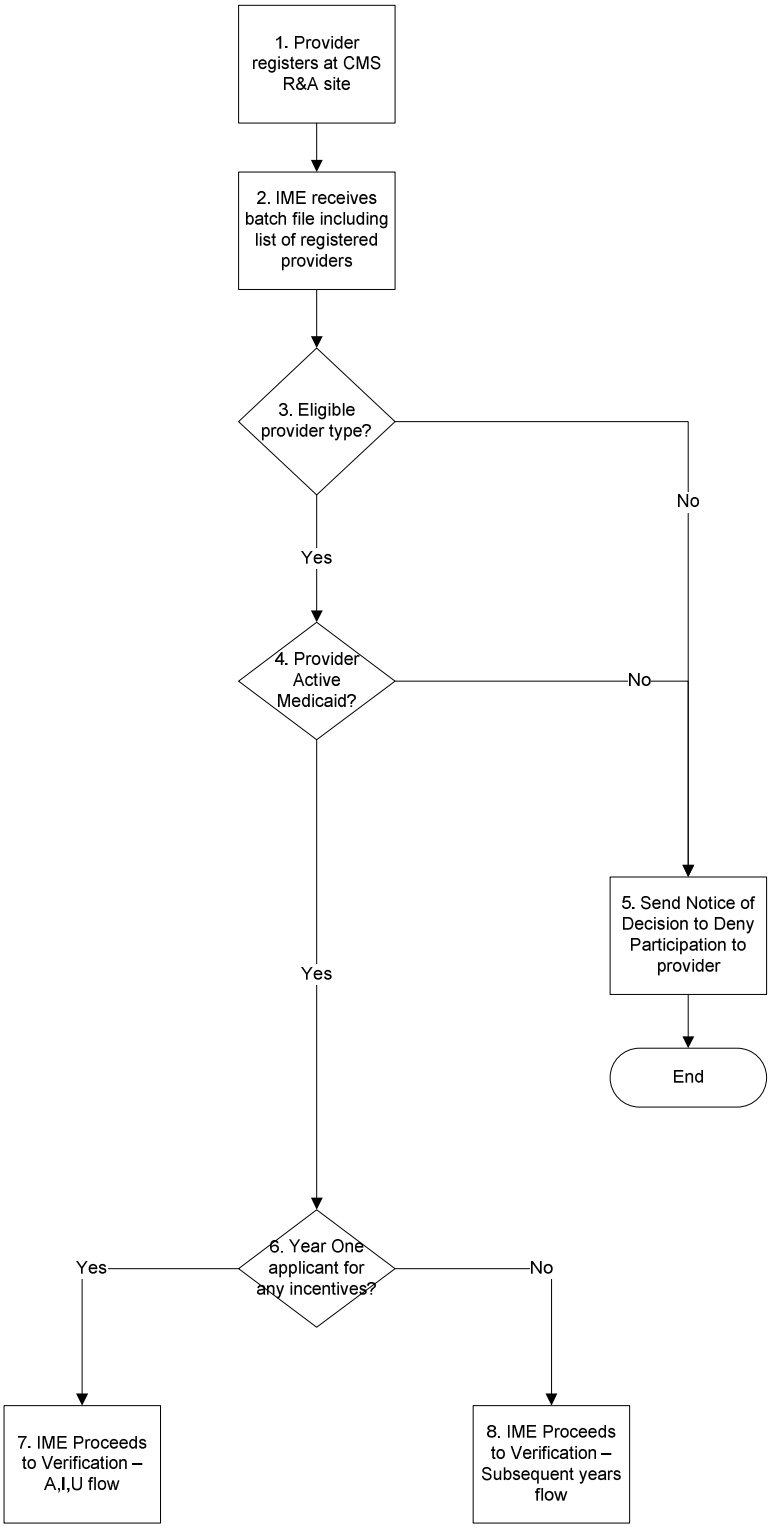
Process flows have been created for

- Preliminary Qualification of the Provider
- Verification of Adoption, Implementation and/or Upgrade
- Verification – Subsequent Years (Meaningful Use)

Preliminary Qualification

This Pre-Qualification flow describes the eligible professional (EP) and eligible hospital (EH) pre-qualification process. The purpose of this flow is to determine early in the process whether the EP or hospital is eligible to receive Medicaid incentive payments.

Pre-Qual


1. Provider registers at CMS R&A site
2. IME receives batch file including list of registered providers
3. Eligible provider type?
No
Yes
4. Provider Active Medicaid?
No
5. Send Notice of Decision to Deny Participation to provider
End
Yes
6. Year One applicant for any incentives?
Yes
No
7. IME Proceeds to Verification – A,I,U flow
8. IME Proceeds to Verification – Subsequent years flow

Pre-Qualification Process Narrative

Step	Action
1	Provider (EP or Hospital) registers with the CMS Registration and Attestation site. This is a site maintained by CMS where providers declare the state from which they are applying to receive Medicaid incentive payments. This registry is also used to prevent duplicative payments with Medicare for EPs. Providers are required to provide basic data, such as their NPI, SSN, payee TIN (if assigning their payment) and hospitals provide their CCN.
2	The IME is notified of a provider's application via daily batch file from CMS. The daily batch is fed into the Iowa Medicaid Portal Access (IMPA) system, an online application designed to support provider re-enrollment and communication. IMPA was enhanced to support the incentive payment program. IMPA then sends a file to the workflow management system, OnBase. Once it arrives in OnBase, it is placed in an Initial Review queue for the EHR worker to make the initial checks for eligibility. One of two enrollment staff work the queues daily in OnBase.
3	Eligible provider type? This will be the first check the enrollment staff person makes to determine the initial eligibility. ARRA authorizes payments only to certain provider types If the provider is an eligible provider type, proceed to Step 4. If the provider is not an eligible provider type, proceed to Step 5.
4	Provider active Medicaid? An active Medicaid provider is one who is active on the MMIS and approved to bill for services. Active Medicaid providers are not currently under sanctions and are duly licensed within the State of Iowa. The enrollment staff person will research the NPI in MMIS to ensure the provider is enrolled (unless the provider is a physician assistant). In the case of a PA, or other EP who is not required to enroll in Medicaid per enrollment rules, the worker researches the applicable Licensing Boards website to ensure the EP is licensed in Iowa. Proof of Medicaid billing through a physician will be required later in the process. If the provider is active Medicaid according to the MMIS, the provider has passed the OIG sanctions and licensing checks as part of the enrollment process. The CMS Registration and Attestation site will also have checked for OIG sanctions. If the provider is not active Medicaid, proceed to Step 5. If the provider is active Medicaid, proceed to Step 6.
5	Through IMPA, the IME will electronically send the Notice of Decision to Deny Participation to provider. If the provider fails to meet the minimum criteria (inactive Medicaid, ineligible provider type, hospital-based EP, patient threshold, inform the provider of ineligibility by issuing the Notice of Decision to Deny Participation and delivering it through IMPA to the provider. This notice informs the applicant of their appeal rights and contains language of alternate solutions to providers to help them with EHR adoption (such as the HITREC). The CMS Registration and Attestation site is notified of this decision through the B-7 interface. This ends the process.
6	Year one incentives are available for providers demonstrating the adoption, implementation, or upgrade of an existing EHR or meaningful use, whereas

Step	Action
	subsequent years require a demonstration of meaningful use. The only exception is dually eligible hospitals who apply for a Medicare MU payment in the same year as their first participation year in Medicaid. If this is a Year one recipient, meaning this is the first year they have applied for incentives, and presumably are going for A/I/U, Proceed to Step 7. If the provider is a subsequent year applicant, go to Step 8. This step triggers a B-7 interface to the CMS Registration and Attestation site alerting CMS of the eligibility of the provider. The CMS Registration and Attestation site will track whether providers have previously received payment from Iowa, and the provider's first participation year.
8	Proceed to the Verification – Adopt, Implement, Upgrade applicant flow.
9	Proceed to the Verification - Subsequent Years flow.

Eligibility

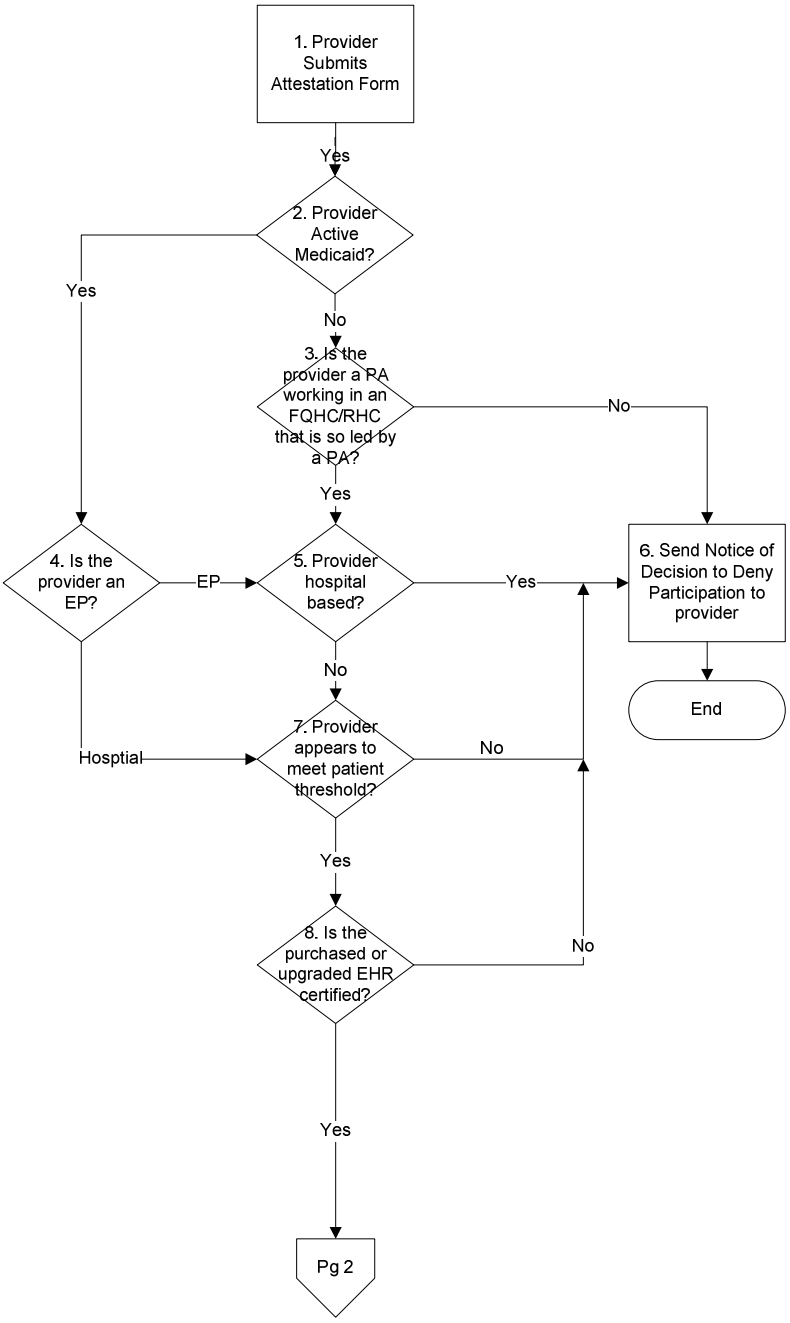
Step 4 of the Pre-Qualification flow requires a check for active Medicaid. Part of the existing Medicaid enrollment process is to ensure the provider is not sanctioned and is a properly licensed/qualified provider. Therefore, if a provider is actively enrolled in Medicaid, the IME can assume there are no pending sanctions against the provider. This step is repeated later in the process, and a manual check for good standing will be conducted immediately prior to issuance of a payment to eliminate any possibility of payment to a sanctioned provider.

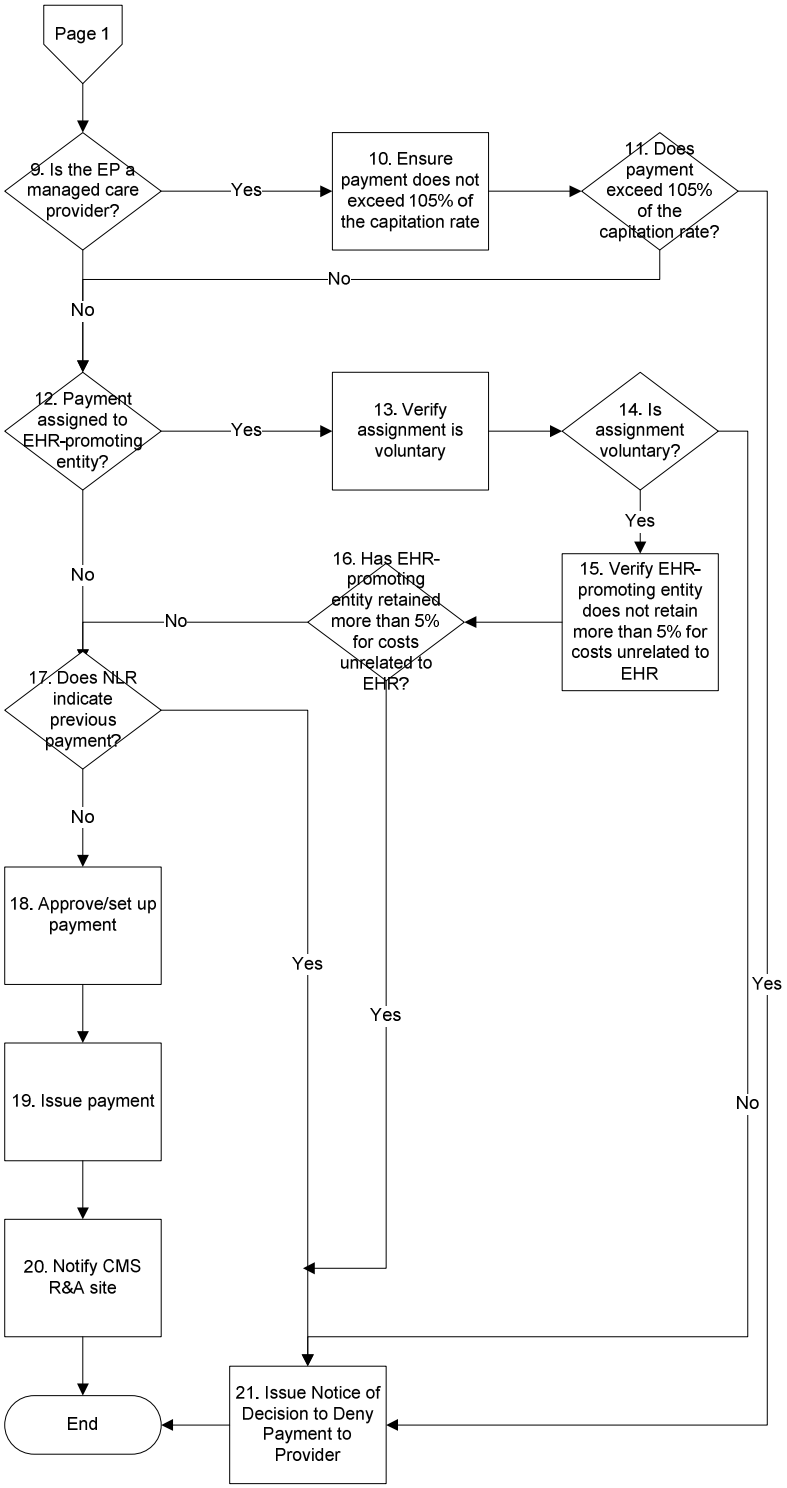
The IME will obtain identifying information regarding the applying provider from the CMS Registration and Attestation site. The IME staff will locate the provider on the MMIS to verify NPI and TIN combination. Currently, the MMIS stores e-mail addresses for all providers and the CMS Registration and Attestation site also provides e-mail addresses for applicants, but is an optional field for applicants. Where necessary, the IME staff contacts the providers using these e-mail addresses. If no e-mail address is provided, the IME calls the provider to obtain an email address and updates MMIS accordingly. While the IME uses both e-mail and phone for initial communication, all subsequent provider communication is primarily through IMPA where the provider completes attestation and tracks the status of the application.

Verification – Adopt, Implement, Upgrade Applicant Process Flow

Providers who begin adopting, implementing, or upgrading certified EHR technology in their first year (between 2011-2016) will be eligible for the incentive payments. In this section, the IME describes the process for paying providers who adopt, implement, or upgrade certified EHR technology. For hospitals, in accordance with the deeming requirements of the final rule, if Medicare approves payments to hospitals, Medicaid will accept the finding of meaningful use. However, patient volume threshold will still need to be validated for eligible hospitals.

Verification – Adopt, Implement, Upgrade Applicant




Page 1
9. Is the EP a managed care provider?
Yes
10. Ensure payment does not exceed 105% of the capitation rate
11. Does payment exceed 105% of the capitation rate?
No
No
12. Payment assigned to EHR-promoting entity?
Yes
13. Verify assignment is voluntary
14. Is assignment voluntary?
Yes
No
16. Has EHR-promoting entity retained more than 5% for costs unrelated to EHR?
15. Verify EHR-promoting entity does not retain more than 5% for costs unrelated to EHR
No
17. Does NLR indicate previous payment?
No
18. Approve/set up payment
Yes
Yes
Yes
No
19. Issue payment
20. Notify CMS R&A site
End
21. Issue Notice of Decision to Deny Payment to Provider

Verification –Adopt, Implement, Upgrade Applicant Process Narrative

Step	Action
1	If the worker determines the provider meets the minimum criteria to apply for the payment, the worker moves the application to a "Waiting for Attestation" queue in OnBase. This move sends a B7 file to the CMS Registration and Attestation site to indicate the provider is in active status in Iowa. This move also sends an updated status to IMPA so the provider can see that initial checks have been approved and that the provider can move forward with attestation. The provider completes online attestation in IMPA. Legal requirements include signature (to be obtained electronically), provider payment information, minimum patient volume and the designated continuous 90-day period. Hospitals attest that average length of stay is 25 days or fewer. When attesting, providers affirmatively acknowledge that proof of all assertions should be maintained for six years in the event of an audit. Examples of proof of purchase or upgrade to certified EHR technology for attestation could include: Proof of purchase of certified EHR – invoice listing EHR version purchased and subsequent proof of payment, etc. The system documents that these requirements have been sworn to and provides an audit trail to track the secure login id of the person attesting.
2	Is provider active Medicaid? Although this step was completed in the pre-qual flow, it should be repeated here. If the provider is not active Medicaid, proceed to Step 4. Otherwise, proceed to Step 3.
3	Is the provider a PA working in an FQHC/RHC that is so led by a PA? The IME does not enroll physician's assistants as a provider type. However, certain PAs are eligible to receive incentive payments. The IME works with these providers to identify acceptable proof of eligible provider type, as well as proof that the FQHC/RHC is so led by a PA. This proof will be in the form of an attestation. If additional documentation is requested as a result of an audit, the provider will upload the documentation through IMPA. Some provider types will require more up-front reviews than others. For example, out-of-state providers may be required to submit additional proof of patient volume if some of their patients are covered by other state's Medicaid programs. Also, because PAs are not currently enrolled in Medicaid, they are required to provide more proof of eligibility prior to payment than other provider types. If the provider is a PA who appears eligible for incentives, proceed to Step 4. If an un-enrolled provider has applied, proceed to Step 9.
4	Is the provider an EP? If the applicant is an eligible professional, proceed to Step 5. If the provider is a not an EP, i.e., is a hospital, proceed to Step 9.

Step	Action
5	Is the provider hospital based? Individual providers who are deemed to be "hospital-based" are not eligible to receive the incentive payment and proceed to Step 9. If the provider is not hospital-based, proceed to Step 7. This step may require coordination with other states if the providers see patients across state lines.
6	Through OnBase, issue the Notice of Decision to Deny Payment to provider. If the provider is not an eligible professional or hospital, is not active Medicaid, has applied to receive Medicare payments or Medicaid payments from another state, is not using a certified EHR, does not patient volume requirements, or has failed to demonstrate A/I/U, inform the provider they are not eligible for payment by issuing the Notice of Decision to Deny Payment. This notice contains language of alternate solutions to providers to help them with EHR adoption (such as the HITREC), as well as notice of their appeal rights. This is communicated by issuing a paper document from OnBase, and the denial is passed to the CMS Registration and Attestation site in a B7 file. This ends the process.
7	Providers not meeting the required patient threshold are not eligible to receive the incentive payment and the process ends; proceed to Step 6. If the provider appears to meet the minimum patient threshold, proceed to Step 8. The IME will access claims data to determine the number of Iowa Medicaid patients billed in the 90-day period designated by the provider. The provider is required to indicate both the numerator and the denominator, along with the beginning and end dates of the 90-day period. The IME gauges whether the numbers provided are realistic, or raise red flags in which the provider will be contacted and asked to provide additional information. This step also includes calculating the needy individual patient threshold for an EP practicing in an FQHC/RHC. This step may also require coordination with other states for those providers seeing patients covered by other state's Medicaid program. We have found that we rely heavily on the provider's records to also validate the numerator, especially in cases where the encounters are bundled into one claim (such as in an OB patient) or where the encounters are billed only at a facility level (such as an FQHC or a family planning clinic) where the individual EPs are not required to enroll separately in Iowa Medicaid.
8	Is the adopted or upgraded EHR certified? In the step, the IME verifies that the provider's EHR is certified. Before attestation, the provider must enter the CMS EHR certification into the IMPA tool. A webservice calls the CHPL to validate the number. The IME staff validates the purchase of the EHR through documentation supplied by the provider or the EHR vendor. If the EHR is not certified or was not purchased by the provider, proceed to Step 6. Otherwise, proceed to Page 2 – Step 9.

Step	Action
9	Is the EP a managed care provider? In Iowa, this check is restricted to Magellan providers. Magellan is Iowa's only Managed Care Organization (MCO). If the provider is Managed Care and a payment may be issued to Magellan, proceed to Step 10. Otherwise, proceed to Step 12.
10	Ensure payment does not exceed 105% of the capitation rate. Payments made through managed care plans cannot exceed 105% of the capitation rate, in compliance with Medicaid managed care incentive payment rules. This rule applies only for providers who will be paid through Magellan, as Iowa's one and only managed care organization. Proceed to Step 11.
11	If the payment is found to exceed 105% of the capitation rate, the payment cannot be made; proceed to Step 21. If the payment is found to not exceed 105%, proceed to step 12.
12	Payment assigned to EHR-promoting entity? Providers are permitted to assign their incentive payments to state-designated entities promoting the use of EHR and HIT. There is no such state-designated entity in Iowa. If there is such an assignment in place, go to Step 13. Otherwise, go to Step 18. The verification of voluntary assignment and 5% spending applies only to EHR-promoting entities, not to payments assigned to employers. We do not see any additional requirements around assignment of payments to employers. We understand the check will be to verify the TIN/NPI combination, a check that will take place regardless of whether there is an assignment.
13	Verify assignment is voluntary. The provider must assert the assignment to the entity is voluntary. The rule requires all assignments to an entity promoting the adoption of certified EHR technology are voluntary to the EP involved. Proceed to Step 14.
14	Is assignment voluntary? If the assignment is found to be voluntary, proceed to step 15. Otherwise, proceed to Step 21.
15	Verify EHR-promoting entity does not retain more than 5% for costs unrelated to EHR. The rule requires entities promoting EHR technology to not retain more than 5% for costs not related to certified EHR technology. Since Iowa has not designated an EHR-promoting entity, there is no existing process for this step. If Iowa does designate an entity in the future, we will update this SMHP with those processes.
16	If the EHR-promoting entity is found to spend more than 5% of the incentive payment for costs unrelated to EHR adoption, proceed to Step 21. Otherwise, proceed to Step 17.
17	Prior to issuing payment, there will be one final check against the CMS Registration and Attestation site through the D16 request and respond files to ensure no payments have been made to the provider by another state or Medicare. If no payment has already been made for the payment year, proceed to Step 18. Otherwise, proceed to Step 21.

Step	Action
18	Approve/set up payment. This step includes creating a gross adjustment request in OnBase and the gross adjustment workers creating the gross adjustment in the MMIS. The gross adjustment indicates the amount of the incentive payment and the appropriate payee. Proceed to Step 19.
19	Issue payment. This step includes the MMIS issuing the payment as part of the weekly payment cycle. The payment shows up on the regular remittance advice statement as a separate line item with a comment that the payment is an EHR incentive payment. The payment is documented for reporting and auditing purposes. Proceed to Step 22.
20	Notify CMS Registration and Attestation site. This notice is provided to prevent duplicative payments by Medicare (EPs only) and to ensure payments made from only one state. This is completed through the D18 transaction.
21	Through OnBase, issue the Notice of Decision to Deny Payment to provider. If the provider is not an eligible professional or hospital, is not active Medicaid, has applied to receive Medicare payments or Medicaid payments from another state, is not using a certified EHR, does not patient volume requirements, or has failed to demonstrate AIU, inform the provider they are not eligible for payment by issuing the Notice of Decision to Deny Payment. This notice contains language of alternate solutions to providers to help them with EHR adoption (such as the HITREC), as well as notice of their appeal rights. This is communicated by issuing a paper document from OnBase, and the denial is passed to the CMS Registration and Attestation site in a B7 file. This ends the process.

Review Process

The IME instituted a process in which the entire review is completed twice by two EHR review workers working independently. This approach serves not only a quality control function, but also ensures that not one person has control over the entire approval process. In the event there is disagreement on whether to issue the payment, the application goes to a conflict queue in OnBase for the incentive payment coordinator to review and break the tie. Even with the two-level review, applications are reviewed on a timely basis, usually with both reviews completed within one week of attestation.

Provider Attestation

As indicated in step one of the Adopt, Implement, Upgrade Applicant flow, the attestation form contains a number of data elements, many of which the IME verifies, with more in-depth verifications occurring in the event of an audit.

The IME verifies the TIN and NPI combination received from the CMS Registration and Attestation site in the MMIS in compliance with 42 CFR 495.10(f). This check will ensure that the individual NPI has a relationship with the TIN provided. We have found many provider applicants whose enumeration with NPPES is different from how they are enrolled with, and subsequently bill, the IME. In these instances, the IME verifies the relationship through a check of NPPES data. If necessary, the IME will request

proof from the provider of the relationship with the payee TIN indicated on the application.

Providers are required to submit receipts or other proof of financial commitment at time of EHR Incentive Request. In the event of an audit providers may be required to provide additional receipts/documentation.

Provider attestation is completed online, with the use of an electronic signature. The electronic signature contains a statement that the "signing" provider is authorized to receive payment, that all information provided is accurate, the provider is subject to legal penalty for providing false information, and that any funds expended under false pretenses will be recouped. An additional agreement is required for those providers who are not enrolled in Iowa Medicaid individually, such as Physician's Assistants or providers employed by a rural health clinic who bill under the RHC. The attestation questions and both EHR provider agreements are provided in Appendix E.

Adopt, Implement, Upgrade

For providers applying for payments based on adopting, implementing, or upgrading to a certified EHR, the IME will verify that the EHR that was adopted, implemented or upgraded is certified. All providers are required to provide a certification number that can be verified with the Certified HIT Product List (CHPL) through a webservice.

The provider as part of attestation must provide proof of adoption/ implementation or upgrade. Acceptable proof includes a contract, service agreement or a purchase receipt.

Payment Calculation EPs

For the first payment year, payment will not exceed 85 percent of the maximum threshold, or $21,250. Year two payments based on 90-days of meaningful use will be $8,500. Pediatricians with a Medicaid patient volume between 20% and 30% receive 2/3 of that amount, $14,167 for the first payment year and $5,667 for subsequent years, not to exceed $42,500.

Hospitals

The IME calculates the hospital payment based on a template spreadsheet found in Appendix D. The auditable data source for the hospital-specific entries is typically the hospital's submitted Medicare cost report. For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Therefore, the inpatient bed day of a dually eligible patient cannot be counted in the Medicaid share numerator. In addition, nursery and swing bed (skilled nursing) days are not counted in the discharge number for purposes of calculating the incentive payment amount.

The IME pays hospitals on a three-year basis, with 40% of the payment in year one, 40% of the payment in year two, and 20% of the payment in year three, assuming the hospital meets the patient volume threshold each year, and meaningful use

requirement are met for years two and three. In the event there is a significant change to the hospital numbers that requires a recalculation of the incentive payment amount, the IME is willing to re-visit the initial payment amount determined in the year one participation year.

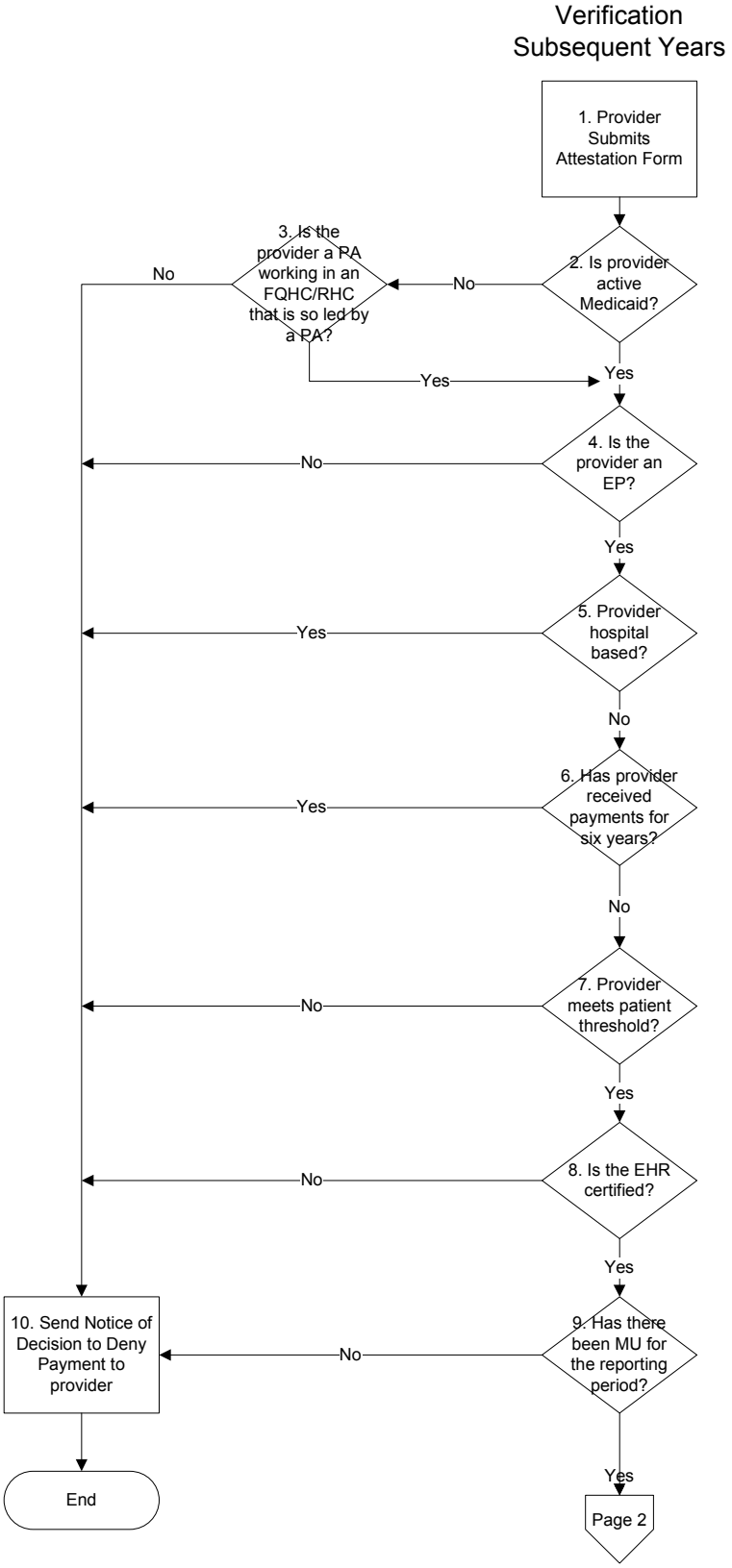
Payment Frequency

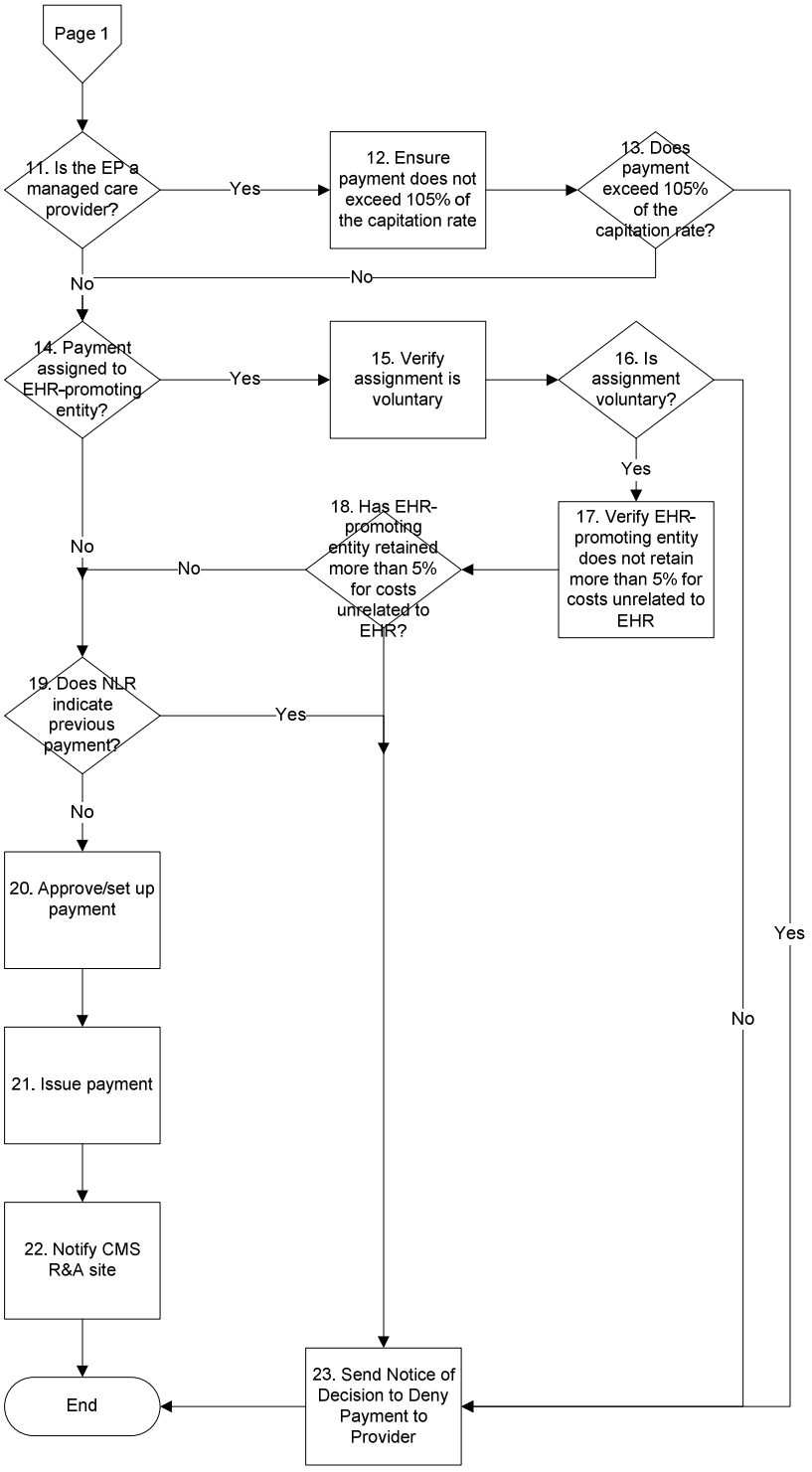
Once approved, incentive payments are issued from MMIS as part of the weekly payment cycle. Most providers receive their payments within 30 days of successfully completing their registration and attestation requirements. We have experienced a number of delays based on issues with the CMS Registration and Attestation site.

Verification – Subsequent Years

Eligible providers who meaningfully use certified EHR technology will qualify for the Medicaid incentive payments. Iowa is currently building out its existing attestation survey to include questions for meaningful use and clinical quality measures. These questions are for both the yes/no questions and for those that require a numerator and denominator. This section describes the process for verifying meaningful use and issuing and tracking the incentive payments.

Verification – Subsequent Years Flow




Page 1
11. Is the EP a managed care provider?
Yes
12. Ensure payment does not exceed 105% of the capitation rate
13. Does payment exceed 105% of the capitation rate?
No
No
14. Payment assigned to EHR-promoting entity?
Yes
15. Verify assignment is voluntary
16. Is assignment voluntary?
Yes
No
18. Has EHR-promoting entity retained more than 5% for costs unrelated to EHR?
No
17. Verify EHR-promoting entity does not retain more than 5% for costs unrelated to EHR
19. Does NLR indicate previous payment?
Yes
No
20. Approve/set up payment
21. Issue payment
22. Notify CMS R&A site
End
23. Send Notice of Decision to Deny Payment to Provider
Yes
No

Verification – Subsequent Years Narrative

Step	Action
1	If the worker determines the provider meets the minimum criteria to apply for the payment, the worker moves the application to a "Waiting for Attestation" queue in OnBase. This move sends a B7 file to the CMS Registration and Attestation site to indicate the provider is in active status in Iowa. This move also sends an updated status to IMPA so the provider can see that initial checks have been approved and that the provider can move forward with attestation. The provider completes online attestation in IMPA. Legal requirements include signature (to be obtained electronically), provider payment information, minimum patient volume and the designated continuous 90-day period. Hospitals attest that average length of stay is 25 days or fewer. When attesting, providers affirmatively acknowledge that proof of all assertions should be maintained for six years in the event of an audit. Examples of proof of purchase or upgrade to certified EHR technology for attestation could include: Proof of purchase of certified EHR – invoice listing EHR version purchased and subsequent proof of payment, etc. The system documents that these requirements have been sworn to and provides an audit trail to track the secure login id of the person attesting.
2.	Is provider active Medicaid? Although this step was completed in the Pre-Qual flow, it should be repeated here. An active Medicaid provider is one who is active on the MMIS and approved to bill for services. Active Medicaid providers are not currently under sanctions and are duly licensed within the state of Iowa. If the provider is not active Medicaid, proceed to Step 3. Otherwise, proceed to Step 4.
3	Is the provider a PA working in an FQHC/RHC that is so led by a PA? The IME does not enroll physician's assistants as a provider type. However, certain PAs are eligible to receive incentive payments. The IME will work with the provider to identify acceptable proof of eligible provider type, as well as proof that the FQHC/RHC is so led by a PA. This proof will be in the form of an attestation. If additional documentation is requested as a result of an audit, the provider will upload the documentation through IMPA. Some provider types will require more up-front reviews than others. For example, out-of-state providers may be required to submit additional proof of patient volume if some of their patients are covered by other state's Medicaid programs. Also, because PAs are not currently enrolled in Medicaid, they will be required to provide more proof of eligibility prior to payment than other provider types. If the provider is a PA who appears eligible for incentives, proceed to Step 4. If the inactive Medicaid provider has applied, proceed to Step 10.
4	If the provider is an eligible professional, proceed to Step 5. If the provider is not an eligible professional (i.e., a hospital), proceed to Step 10.

Step	Action
5	Provider hospital based? Individual providers who are deemed to be "hospital-based" are not eligible to receive the incentive payment and proceed to Step 10. If the provider is not hospital-based, proceed to Step 6. This step may require coordination with other states if the providers see patients across state lines.
6	Has provider received payments for six years? This is the check to ensure providers have not received payments for more than six years. This check also includes a check to make sure there hasn't been more than one switch between Medicare and Medicaid. If the provider has received payments for more than six years, or has switched between the programs more than once, proceed to Step 10. If the provider has not received payments for six years and has not switched between the programs more than once, proceed to Step 7. The system will track whether providers have previously received payment from Iowa. We also expect the CMS Registration and Attestation site to provide previous years' payments from other states, as well as payments received from Medicare.
7	Providers not meeting the required patient threshold are not eligible to receive the incentive payment and the process ends; proceed to Step 6. If the provider appears to meet the minimum patient threshold, proceed to Step 8. The IME will access claims data to determine the number of Medicaid patients billed in the 90-day period designated by the provider. The provider will be required to indicate both the numerator and the denominator. The IME will gauge whether the numbers provided are realistic, or raise red flags in which the provider will be contacted and asked to provide additional information. This step also includes calculating the needy individual patient threshold for an EP practicing in an FQHC/RHC. This step will involve the use of calculation instructions. This step may also require coordination with other states for those providers seeing patients covered by other state's Medicaid program.
8	Is the EHR certified? In the step, the IME verifies that the EHR is certified through calling the CHPL web service. If the EHR is not certified, proceed to Step 10. Otherwise, proceed to Step 9.
9	Has there been meaningful use for the reporting period? This step verifies the mandated objectives and measures for meaningful use have been met for the reporting period in the payment year. For the first year of meaningful use, this is a continuous 90 day period within the payment year. For subsequent years the reporting period is the entire year. Medicaid will capture and verify required data. If MU is met, proceed to page 2 (Step 11). If meaningful use is not met, proceed to Step 10.

Step	Action
10	Send Notice of Decision to Deny Payment to provider. If the provider is not active Medicaid, has applied to receive Medicare payments or Medicaid payments from another state, is not using a certified EHR, or has failed to demonstrate MU for the entire year, inform the provider they are not eligible for payment by issuing the Notice of Decision to Deny Payment. This notice contains language of alternate solutions to providers to help them with EHR adoption (such as the HITREC). This ends the process.
11	Is the EP a managed care provider? In Iowa, this check is restricted to Magellan providers. If the provider is Managed Care and a payment may be issued to Magellan, proceed to Step 12. Otherwise, proceed to Step 14.
12	Ensure payment does not exceed 105% of the capitation rate. Payments made through managed care plans cannot exceed 105% of the capitation rate, in compliance with Medicaid managed care incentive payment rules. Proceed to Step 13.
13	If the payment is found to exceed 105% of the capitation rate, the payment cannot be made; proceed to Step 22. If the payment is found to not exceed 105%, proceed to step 14.
14	Payment assigned to EHR-promoting entity? Providers are permitted to assign their incentive payments to state-designated entities promoting the use of EHR and HIT. There is no such state-designated entity in Iowa. If there is such an assignment in place, go to Step 19. Otherwise, go to Step 15.
15	Verify assignment is voluntary. The provider must assert the assignment to the entity is voluntary. The rule requires all assignments to an entity promoting the adoption of certified EHR technology are voluntary to the EP involved. Proceed to Step 16.
16	Is assignment voluntary? If the assignment is found to be voluntary, proceed to step 17. Otherwise, proceed to Step 22.
17	Verify EHR-promoting entity does not retain more than 5% for costs unrelated to EHR. The rule requires entities promoting EHR technology to not retain more than 5% for costs not related to certified EHR technology. Proceed to Step 18.
18	If the EHR-promoting entity is found to spend more than 5% of the incentive payment for costs unrelated to EHR adoption, proceed to Step 22. Otherwise, proceed to Step 19.
19	Prior to issuing payment, the D16 request ensures one final check against the CMS Registration and Attestation site to ensure no payments have been made to the provider by another state or Medicare. This will be completed through the D16 transaction. If no payment has already been made for the payment year, proceed to Step 20. Otherwise, proceed to Step 22.

Step	Action
20	Approve/set up payment. This step includes creating a gross adjustment request in OnBase and the gross adjustment workers creating the gross adjustment in the MMIS. The gross adjustment indicates the amount of the incentive payment and the appropriate payee. Proceed to Step 19.
21	Issue payment. This step includes the MMIS issuing the payment as part of the weekly payment cycle. The payment shows up on the regular remittance advice statement as a separate line item with a comment that the payment is an EHR incentive payment. The payment is documented for reporting and auditing purposes. Proceed to Step 22.
22	Through OnBase, issue the Notice of Decision to Deny Payment to provider. If the provider is not an eligible professional or hospital, is not active Medicaid, has applied to receive Medicare payments or Medicaid payments from another state, is not using a certified EHR, does not patient volume requirements, or has failed to demonstrate meaningful use, inform the provider they are not eligible for payment by issuing the Notice of Decision to Deny Payment. This notice contains language of alternate solutions to providers to help them with EHR adoption (such as the HITREC), as well as notice of their appeal rights. This is communicated by issuing a paper document from OnBase, and the denial is passed to the CMS Registration and Attestation site in a B7 file. This ends the process.
23	Notify CMS Registration and Attestation site. This notice is provided to prevent duplicative payments by Medicare (EPs only) and to ensure payments made from only one state This is completed through the D18 transaction with the CMS Registration and Attestation site.

Meaningful Use

For providers applying for payments based on meaningful use, the IME first verifies that the EHR is certified. This is currently done through the verification web service with the CHPL. All participating providers must demonstrate meaningful use for the second participation year, but dually eligible hospitals may choose to demonstrate meaningful use in their first year. The IME expects participating hospitals to also apply for the Medicare incentives. Therefore, hospitals meaningful use will be approved by verifying that Medicare has approved their payment by accessing the reports from the CMS registration site.

The IME intends to collect meaningful use measures by building out the existing attestation to include meaningful use questions. For those measures requiring a numerator and denominator, the IME will rely on the provider and their EHR to track and provide documentation of both the numerators and the denominators. The IME expects yes /no questions to be demonstrated through the submission of those measures, either through attestation in the short term or electronically in the longer term. The questions for meaningful use from the EPs can be found in Appendix H.

The IME has no plans to mandate additional meaningful use criteria to the minimum measures required under the rules. Meaningful use verification is accomplished in Step 9 of the Subsequent Years flow. There is currently no other collection and analysis of clinical quality measures data in place at the IME. If one is implemented in the future, the processes for the incentive program will align with those.

Systems Support

Iowa is committed to the use of electronic tools to support the outreach, communication, application and processing of the Electronic Health Record incentive program.

Outreach is utilizing webinars, web-sites, Google groups, electronic informational letters, and electronic survey tools, as well as attending numerous professional group meetings and seminars. Communication is handled via e-mail, web applications and electronic documentation.

Providers begin the registration process through the CMS registration and attestation site, and complete the attestation process through the use of the Iowa Medicaid Provider Application (IMPA). Applications are tracked and processed through our workflow tool (OnBase), and electronic payments are made through the Iowa Medicaid Management Information System (MMIS). Four key systems currently support the IME EHR Incentive program. The IME is currently planning to procure a new system for supporting future administration of the EHR Incentive Payment program.

CMS Registration and Attestation Site: This system provides the registration for provider applications and ensures no duplicate payments between Medicare and the State Medicaid agencies. Iowa successfully completed testing of all files from CMS, including those around Medicare cost reports and meaningful use data and has been receiving registration files from the site since January 3, 2011.

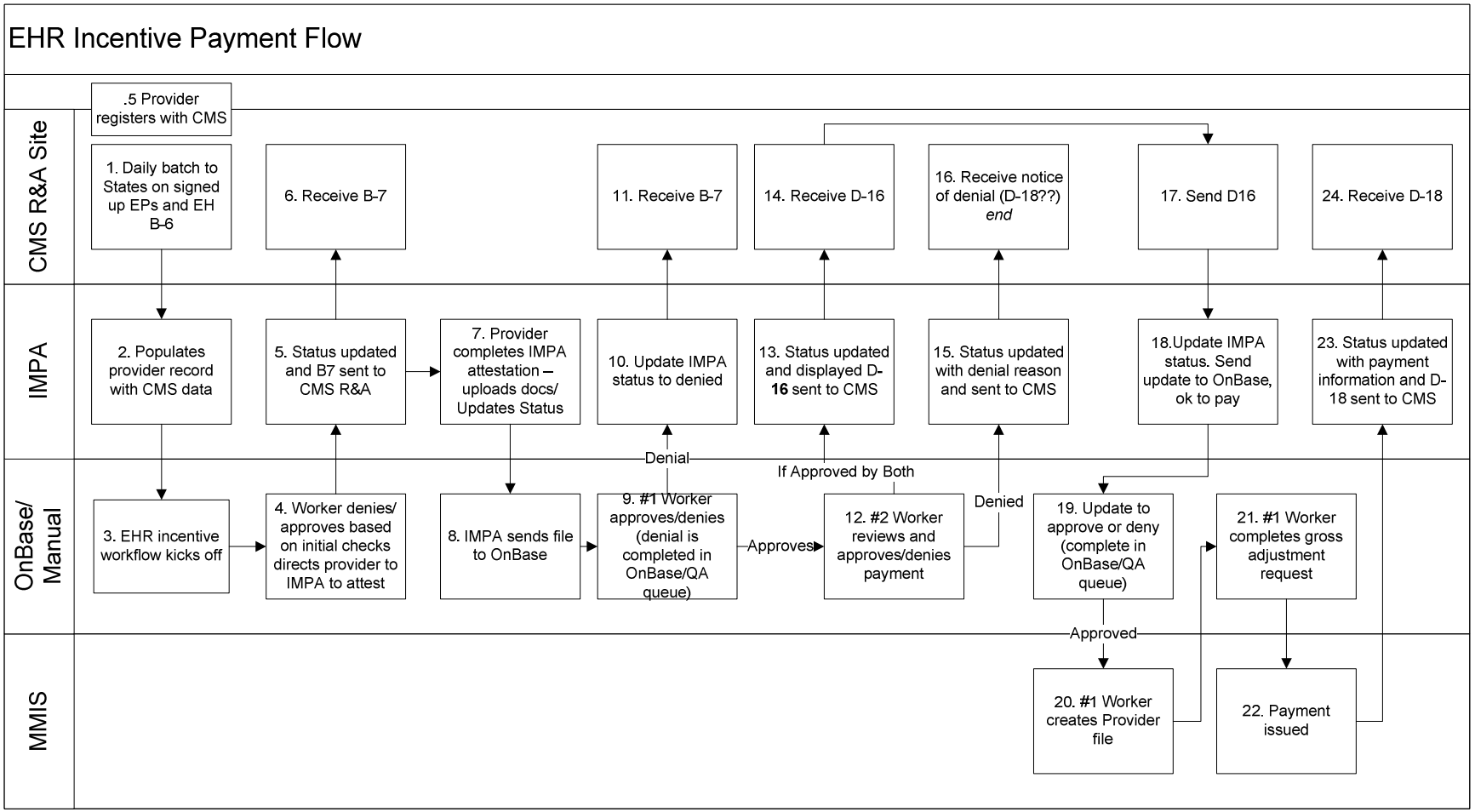
Iowa Medicaid Provider Application (IMPA): IMPA is a secure web portal application providers use to access remittance advice reports, report critical incidents, upload level of care documentation, and register for mailing lists. It has been expanded to support provider re-enrollment and the EHR incentive program.

The IME issued a request for request for information in May 2011. After reviewing the responses, Iowa has determined the best use of resources would be to request proposals for an existing or multi-state solution to capture attestation for meaningful use.

Onbase : Onbase is the workflow management software tool used by Iowa Medicaid Enterprise. It provides access to our imaged documents, workflow task management, and process reporting. Onbase queues have been built to support the review of the attestations and for approving or denying incentive payments.

Medicaid Management Information System (MMIS). The MMIS system manages the provider data store, adjudicates claims and makes payments. All payments are made on a weekly basis through the use of Electronic File Transfers or EBT debit cards. A special provider type was added to support the EHR incentive payment program to aid in tracking and incentive payment issuance.

A diagram showing the workflow interaction between these systems is found on the next page.


EHR Incentive Payment Flow
CMS R&A Site
IMPA
OnBase/ Manual
MMIS
.5 Provider registers with CMS
1. Daily batch to States on signed up EPs and EH B-6
6. Receive B-7
11. Receive B-7
14. Receive D-16
16. Receive notice of denial (D-18??) end
17. Send D16
24. Receive D-18
2. Populates provider record with CMS data
5. Status updated and B7 sent to CMS R&A
7. Provider completes IMPA attestation – uploads docs/ Updates Status
10. Update IMPA status to denied
13. Status updated and displayed D-16 sent to CMS
15. Status updated with denial reason and sent to CMS
18.Update IMPA status. Send update to OnBase, ok to pay
23. Status updated with payment information and D-18 sent to CMS
Denial
If Approved by Both
3. EHR incentive workflow kicks off
4. Worker denies/ approves based on initial checks directs provider to IMPA to attest
8. IMPA sends file to OnBase
9. #1 Worker approves/denies (denial is completed in OnBase/QA queue)
Approves
12. #2 Worker reviews and approves/denies payment
Denied
19. Update to approve or deny (complete in OnBase/QA queue)
21. #1 Worker completes gross adjustment request
Approved
20. #1 Worker creates Provider file
22. Payment issued

IMPA Enhancements

IMPA is an existing web application used by providers for a variety of purposes, such as accessing remittance advice statements and incident reporting. IMPA has been enhanced to support the EHR incentive program, all communications with the provider, as well as options for uploading supporting documentation. The IMPA application manages communication between the CMS registration and attestation site and the Iowa EHR program.

Using an existing connect:direct portal, the IME receives a B6 update from CMS on a daily basis. The data received from CMS is loaded into IMPA. Once the provider initiates an application, IMPA passes this data to OnBase (see below) which then triggers a workflow process. If the worker finds that the provider application passes initial checks, this is completed in OnBase which then passes the status back to IMPA.IMPA then sends the B7 transaction to CMS to indicate the provider has passed initial screening.

To begin the registration process in Iowa, a provider is first required to create an account in IMPA. Once the account is created, the provider selects EHR Incentive Payment Program from a drop down menu. To initiate the EHR incentive application, the provider enters his/her NPI, TIN and CMS registration number. These are the three key pieces of data the IME requires for user authentication purposes and will be verified against the data received from CMS. At this point the provider must also enter the CMS EHR certification number, which then calls the webservice for validation.

The provider can also view the data received from CMS. IMPA is designed so that only an individual can complete the attestation for him/herself. In other words, office administrators, or other entities are not authorized to complete any portion of the IMPA attestation on behalf of a provider. The provider must complete the attestation him/herself.

Once registered, the provider moves to the attestation portion of the application. The questions presented are a function of data received from the CMS registration and attestation site. If CMS indicates this provider is an EP, IMPA displays the EP questions. If the data indicate the provider is a hospital, the EH questions are displayed. The EP questions are divided into five categories: basic qualifications, A/I/U, patient volume, payment information and signature. A sixth category, meaningful use, will be implemented for year 2 payments. The IME is currently reviewing alternatives to custom development for capturing meaningful use attestation.

AIU Attestation Questions - EP

Question Number	Text
1	I am an eligible professional based on the following provider type
	Physician
	Nurse Practitioner
	Dentist
	Certified Nurse Midwife
	Physician Assistant
2	Are you currently enrolled as a Medicaid provider?
	Yes
	No
3	Do you have any sanctions pending against you?
	Yes
	No
4 (presents only if EP is a PA)	My professional license number is
	Numeric
5 (presents only if EP is a PA)	I am currently seeing Medicaid patients billed through my supervising physician.
	NPI entry of supervising physician
6 (presents only if EP is a PA)	Where do you practice predominately?
	FQHC
	RHC
7 (presents only if EP is a PA in an FQHC)	How is your clinic so led by a PA?
	PA Primary
	PA Director
	PA owner
8 (presents only if EP is a PA in an FQHC)	How is your clinic so led by a PA?
	PA Primary
	PA Clinic
9	What is the NPI of the organization through which you bill
	NPI entry
10	Hospital Based - EPs are not eligible for the incentive payment. Are you a hospital based provider?
	Yes
	No
11	What is the percentage of your patients that are seen in a hospital setting (ED or inpatient)?
	89% or less
	90% or more
12	Are you applying for incentives because you have adopted, implemented or upgraded to certified electronic health record (EHR) technology.
	Adopt
	Implement
	Upgrade
13	Are you a pediatrician seeking payment based on 20% of your practice attributable to Medicaid? (Note: if you are a pediatrician with a 30% Medicaid patient volume, answer “no” to this question).

	Yes
	No
14	To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (<tip>needy individuals</tip> for those practicing predominantly in an FQHC or RHC). This calculation can be made at the individual provider level, or at the clinic level. Are you attesting to patient volume based on a clinic-level calculation?
	Clinic Level
	Individual Level
15 (presents when answer to 14 is clinic level)	Please enter the Tax ID and NPI of the clinic
	Tax ID
	NPI entry
16	To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (needy individuals for those practicing predominantly in an FQHC or RHC). Provide the beginning and end dates for the 90-day period you are claiming to prove patient volume requirements
	Start Date
	End Date
17	What is the total number of <tip>patient encounters</tip> within the selected 90-day period? (I.e., your denominator)
	Number of Patients
18	What is the total number of Medicaid encounters for the selected 90-day period? (I.e., your numerator)
	Encounters for the 90 day period
19	What is the percentage of patient encounters over the selected 90-day period that was PAID by Medicaid?
	Percentage entry
20	Are any of your Medicaid patients covered by another state's Medicaid program?
	Yes
	No
21 (presents if yes answered to 20)	Which other states Medicaid programs paid for patient encounters during the selected 90-day period?
	WI
	MN
	SD
	MO
	NE
	IL
	Other
22	Are you a Medicaid managed care provider? (i.e., see patients covered by Magellan or MediPASS?)
	Yes
	No
23 (presents if yes	Are you claiming Medicaid patients from your panel that you have seen in

answered to 22)	the past year, but not in the selected 90-day period, as part of your Medicaid patient percentage calculation?
	Yes
	No
24	Do you see patients in more than one location?
	Yes
	No
25	Did at least 50% of your patient encounters during the EHR reporting period take place at a practice/location or practices/locations equipped with certified EHR?
	Yes
	No
	Addresses
	Address entry
26	What is the verifiable data source you are using to calculate patient volume?
	EHR Report
	Appointment Books
	Other
27	Do you practice predominately in an FQHC or RHC?
	Yes
	No
28	Are 30% of your encounters for needy individuals?
	Yes
	No
29	Of your patients who are needy individuals, provide the number of patients falling into each of the following categories during the designated 90-day period:
	Iowa Medicaid
	Other State's Medicaid
	hawk-i
	Patients
	Patients - Other
30 (presents only if not assigning payment)	EFT Information
	EFT entry
	This part of your application is complete but still needs to be submitted for further review. To submit your application, click on the Attestation Summary link above. After submitted, you can check back on this web site for the results of your application. You are able to print this application for your records on another screen. Questions can be referred to the following email: imeincentives@dhs.state.ia.us.

Attestation Questions – EH

Question Number	Text
	Do you represent an acute care hospital?
	Yes
1	No
	My hospital's CCN is
2	CCN Entry
	Is your average patient length of stay less than 25 days?
	Yes
3	No
	My average patient length of stay is
4	Number of Days entry
	Have you adopted, implemented or upgraded to certified electronic health record (EHR) technology.
	Adopted
	Implemented
5	Upgraded
	To be eligible for the incentive, 10% of your patient encounters (ED and inpatient) over a consecutive 90-day period in the previous hospital fiscal year must be attributable to Medicaid. Which 90-day period will you be using?
	Start Date
6	End Date
	What is the total number of patient encounters for the specified 90 day period?
7	Patient Encounters entry
	Are any of your Medicaid patients covered by another state's Medicaid program?
	Yes
8	No
	Which other state's Medicaid programs paid for patient encounters during the 90-day period?
	WI
	MN
	SD
	MO
	NE
9 (is answered yes to 8)	IL
	Other
	What is the verifiable data source you are using to calculate patient volume?
	EHR Report
	Appointment Books
10	Other
	Hospital Calculator page

At any time during or after attestation, the provider may upload documentation in support of the application. While only a few document types are required to apply, the provider may choose to supply proof to prevent an audit.

Possible supporting documentation may include the following information:

- License issued by the Iowa Board of Physician Assistants (required for PA)
- Provider of ownership for RHC (required for PH working in RHC that is owned by PA)
- Proof of patient volume (required)
- Copy of EHR invoice or contract (required)
- Proof of EP's contract or employment agreement

The provider may return to IMPA to complete/change any responses at any time prior to signing. Once the provider attaches a digital signature, the answers are locked. IMPA stores the responses to the above questions and sends certain data elements to the OnBase workflow management system.

OnBase Enhancements

OnBase is the software supporting the workflow processes. This includes tracking the steps through verification and submitting the official request for payment. The first B6 data received triggers a manual, initial check of eligibility. This includes verifying that the provider is enrolled in Iowa Medicaid, the NPI and tax id correspond, and is not subject to any state exclusions or sanctions. Once this initial check is completed, a file is sent to IMPA which then triggers the B7 to the CMS registration and attestation site.

The IME uses two workers to review the provider's application/attestation for payment. This approach not only ensures accuracy, but also helps to prevent fraud. Once the attestation is complete, IMPA sends core data elements to populate the initial OnBase queue. The worker then verifies the IMPA data against MMIS data to verify enrollment and claims history. The workers also verify other aspects of the application, depending on provider type and existing provider-submitted documentation. If the worker is satisfied that payment is appropriate, the worker moves the application in OnBase for a second worker review. Once the second worker approves, the application moves to a completed queue in OnBase. At this point, an update is sent to IMPA, which then triggers the D16 transaction to the CMS site.

If the returned D16 indicates it is ok to pay, the worker approves the payment. This is completed by creating the file in MMIS (see below) and completing a gross adjustment request in OnBase. The IME uses gross adjustments as the trigger for incentive payments to be made through the MMIS. The approach uses the existing functionality for issuing payments. OnBase has an existing interface with the MMIS for submitting requests for gross adjustments.

MMIS Enhancements

MMIS was enhanced to support issuing payments to providers who qualify for the EHR incentive program. A new provider type (provider type 66) was created to indicate a

provider file created solely for purposes of the incentive payment program. While MMIS already contains files for most of the applying providers (with the exception of physician assistants), the creation of a separate provider was necessary to ensure that payments can go directly to providers who are enrolled as rendering-only providers.

Once the provider file is built in MMIS, the worker triggers the payment in OnBase using the automated gross adjustment request which sends the claim to the MMIS for payment. This form contains the check payment amount and the legacy provider number that was assigned when the file was created in MMIS (note: MMIS contains a cross-walk solution for NPI implementation). When the MMIS receives the file a claims processor reviews and approves the adjustment. Once approved, the payment is issued with the regular weekly payment batch cycle. Payment information from the MMIS updates IMPA directly for transmission to CMS through the D18 transaction. EHR incentive payments appear on the remittance advice statement along with other regularly paid claims, but with a code indicating an EHR payment. A new EOB code was added to indicate the payment is attributable to the EHR incentive payment program.

Eligible professionals are permitted to assign their incentive payments to state-designated entities promoting the use of EHR and HIT. At this time, Iowa has not designated such an entity. If, however, this changes and the state does designate an entity, the IME has built verification steps into the flows to ensure that the assignment is voluntary and that the entity does not retain more than 5% for costs unrelated to EHR promotion.

The process to assure payments through Medicaid managed care plans do not exceed 105 percent of the capitation rate is included in both the Verification-Year One Applicant flow and the Subsequent Years flows.

The steps for calculating the payment for both hospitals and EPs are included in Step 22 of the Verification-Year One Applicant flow and in Step 20 of the Subsequent Years flow. The hospital formula is automated to ensure payments are made according to the statute and regulations.

Calculation of hospital payments will be according to the formula provided in the final rule. In verifying hospital data, the IME will depend on the following data sources:

- Provider's cost reports
- Payment and utilization information from the MMIS
- Hospital financial statements and hospital accounting records

The requested data for hospital discharges is based on the hospital fiscal year that ended in the federal fiscal year prior to the payment year.

Medicaid payments to providers are paid through the MMIS. The payments are made directly to the provider, or to an employer or facility to which such the EP has assigned payment) without any deduction or rebate.

The MMIS reports used to support the CMS-64 and claiming for federal funding of the incentive program have been modified to separately identify the incentive payments.

The IME issues incentive payments to providers according to its regular payment weekly payment schedule.

Appeals

The existing provider appeals process was expanded to include appeals from providers on the basis of the incentive payment amount, provider eligibility determinations and demonstrations of efforts to adopt, implement or upgrade and meaningfully use certified EHR technology. In late 2010, the IME drafted an administrative rule to support the appeals process. The text of this rule can be found in Appendix E.

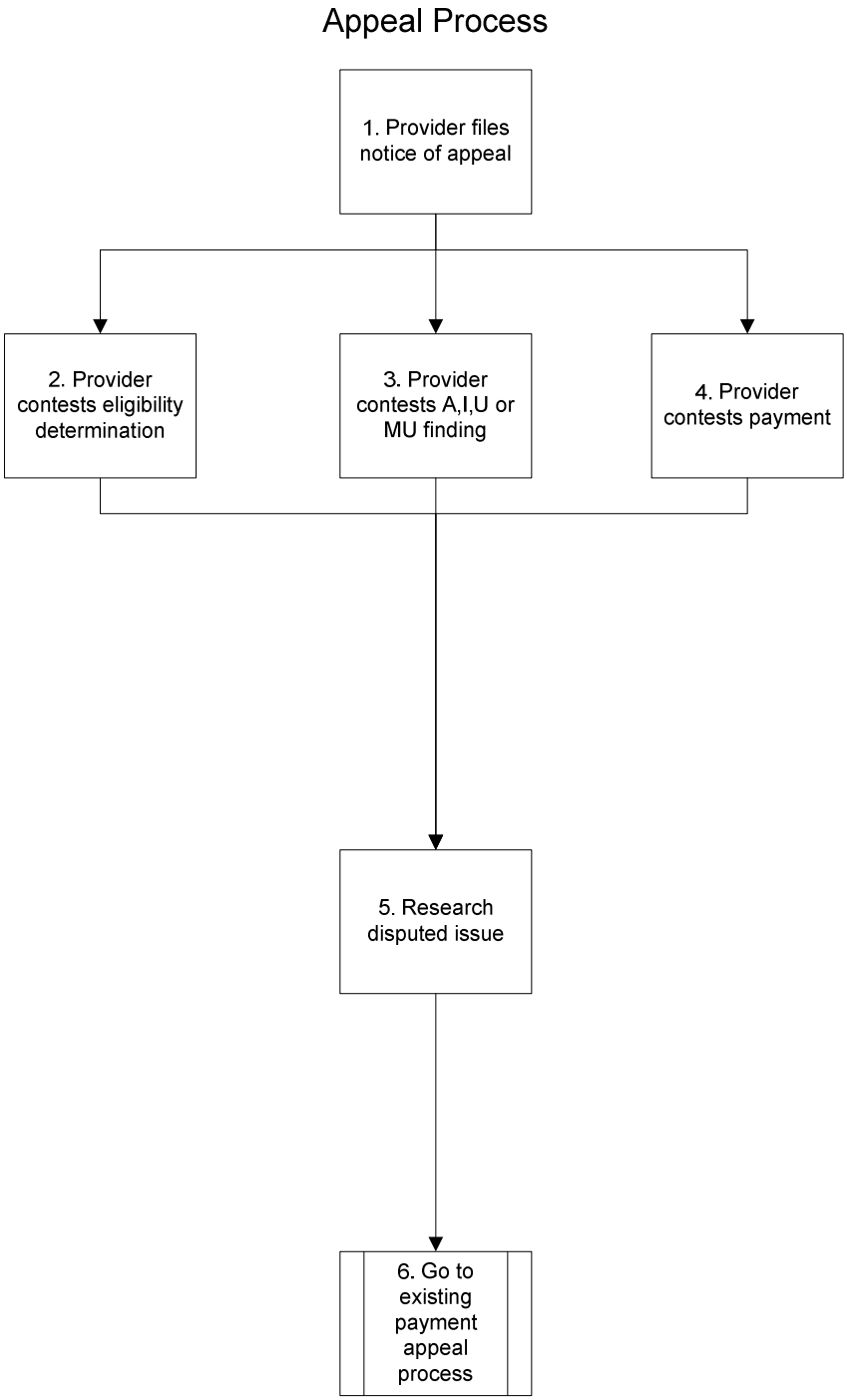
The appropriate IME unit tasked with tracking the appeal depends on the basis for the appeal. Provider Services will handle provider contests to eligibility determinations. The Program Integrity unit will handle contests based on findings of A/I/U or meaningful use. Payment amount disputes will be handled by Provider Cost Audit. To date, there have been no appeals filed as a result of the EHR incentive payment program.

This section provides details of the existing appeals processes as defined in the MITA State Self-Assessment conducted in January 2009. The IME does expect providers to contact the IME prior to initiating a formal appeal. The IME will work with providers to resolve issues without the need for using the appeals process.

The Manage Provider Complaint, Grievance and Appeal business process handles provider appeals of adverse decisions or communications of a complaint or grievance. A complaint, grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The complaint, grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; an appeals hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the appeals hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program Management Business Area by providing data about the types of complaints, grievances and appeals it handles; complaint, grievance and appeals issues; parties that file or are the target of the complaint, grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to complaints, grievances and appeals.

Appeals Process Flow



Appeal Process Narrative

Step	Action
1	Provider files notice of appeal by one of three mechanisms: 1. Complete an appeal electronically at a. https://dhssecure.dhs.state.ia.us/forms/appealrequest.htm, or 2. Write a letter telling us why you think a decision is wrong, or 3. Fill out an *Appeal and Request for Hearing* form. The IME expects providers to contact the IME prior to initiating a formal appeal. The IME will work with providers to resolve issues without the need for using the appeals process. For the nine applications that have been denied, the IME staff reached out to the denied providers to explain the reason for denial, as well as options for re-applying.
2	Provider contests eligibility determination? Providers may be denied eligibility for the incentive program if they do not meet the minimum patient threshold or if they are not the correct provider type. Providers may contest this finding.
3	Provider contests A/I/U or MU finding? Providers may be denied incentive payments on the basis they did not successfully demonstrate efforts to adopt, implement or upgrade, or to show meaningful use. Providers may contest this finding.
4	Provider contests payment? The amount providers are paid is based on their participation year, whether the provider is a pediatrician, and possibly other factors, particularly with the hospital payment formula. Providers may contest this finding.
5	Verify disputed issue. Providers must submit documentation to support their claim. This documentation is researched to determine whether the IME decision is found to be correct. Providers may appeal that the process was not followed, but cannot appeal the process itself.
6	Go to existing payment appeal process. This is the existing process for responding to provider appeals.

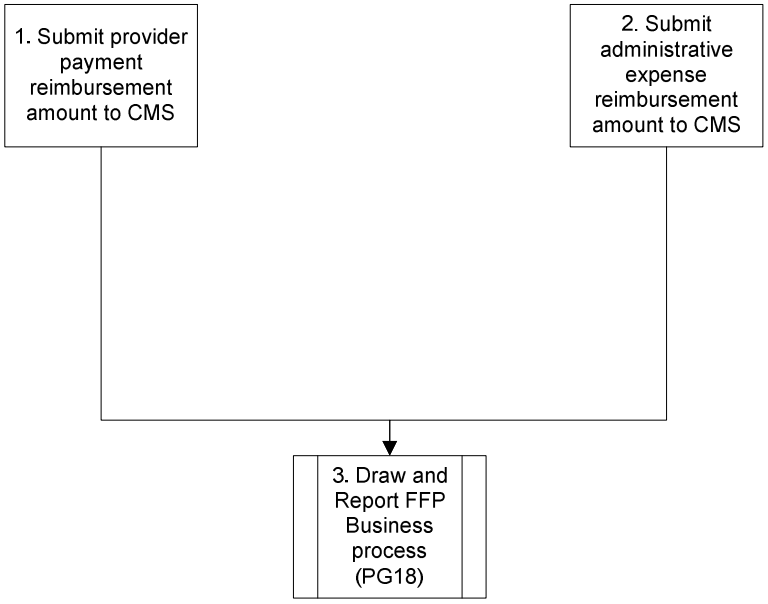
Claiming FFP

The IME provides assurances that amounts received with respect to sums expended that are attributable to payments to a Medicaid provider for the adoption of EHR are paid directly to the provider, or to an employer or facility to which the provider has assigned payments without any deduction or rebate.

This section describes the process for ensuring no more than 100% FFP is claimed for reimbursement of incentive payments made to providers, and that no more than 90% of FFP is claimed for the administrative costs of administering the program. These steps leverage existing processes followed for claiming FFP for Medicaid expenditures.

Claim Federal Reimbursement Flow

Claim Federal Reimbursement



Claim Federal Reimbursement Narrative

Step	Action
1	495.332(c)(7) a description of the process in place to ensure that no amounts higher than 100 percent of FFP will be claimed for reimbursement of expenditures for State payments to Medicaid EPs for the incentive program and a methodology for verifying such information is available. Payments claimed will be consistent with the guidance provided in SMD# 10-016.
2	495.332(c)(7) a description of the process in place to ensure that no amounts higher than 90 percent of FFP will be claimed for administrative expenses in administering the incentive program and a methodology for verifying such information is available. The new CMS-64 forms provide lines for the reporting of HIT administrative activities reimbursable at 90% (Lines 24A – 24D)
3	Existing processes as documented in the IME MITA State Self-Assessment Report, June 1, 2009, (Business Process Number: PG18) will be followed for both types of reimbursement reporting.

The Draw and Report FFP business process (PG18) involves the activities to assure that federal funds are properly drawn and reported to CMS. The state is responsible for assuring that the correct FFP rate is applied to all expenditures in determining the amount of federal funds to draw. When CMS has approved a State Plan, it makes quarterly grant awards to the state to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the state to draw federal funds as needed to pay the federal share of disbursements. The state receives federal financial participation in expenditures.

CMS can increase or decrease grant awards because of an underestimate or overestimate for prior quarters. Payment of a claim or any portion of a claim for FFP can be deferred or disallowed if CMS determines that the FFP claim is incorrectly reported or is not a valid expenditure.

Other Process Design Considerations

MITA Impacts

The IME intends to leverage the following business processes, as defined in the MITA 2009 self-assessment:

1. PM01 – Enroll Provider
2. PM03 – Inquire Provider Information
3. PM04 – Manage Provider Communication
4. PM05 – Manage Provider Grievance and Appeal
5. PM06 – Manage Provider Information
6. PM07 – Perform Provider Outreach
7. PG08 – Manage FFP for MMIS
8. PG09 - Manage F-Map
9. PG10 – Manage State Funds
10. PG11 – Manage 1099s
11. PG18 – Draw and report FFP
12. PG19 – Manage FFP for Services
13. PI01 – Identify Candidate Case
14. PI02 – Manage Program Integrity Case

IME Assumptions and Dependencies

The IME has the following assumptions and dependencies:

The IME expects to receive daily batch updates from CMS, with an eventual manual, web-based, look-up capability for the IME to check the status of any given provider

The IME expects timely reimbursement, or advance payment, from CMS in alignment with the payment schedule to providers

The IME's anticipated challenges include operating under budget constraints, numerous other initiatives, and staff reductions

CMS Data Elements

The IME receives the following data elements from the CMS daily batch:

- Provider name
- Provider individual NPI
- Provider type
- Provider business address

- Provider business phone
- TIN to which the provider wants the payment made
- CCN for eligible hospitals
- Provider registration number

The IME sends to CMS the following data elements:

- Amount of payment (if a previous payment was made from Medicare or another state)
- Date of payment (if a previous payment was made from Medicare or another state)
- Reason codes for ineligibility (if previously denied by Medicare or another state

Section D: Iowa's Incentive Payment Audit Strategy

Proposed Program Integrity Strategies

Iowa's Incentive Payment Audit Strategy describes the process(es) required for ensuring the accurate payment of the EHR Incentives to Iowa's providers. This section describes the process for combating fraud and abuse by verifying criteria related to the EHR incentives payment program, as well as a description of the process and methodology to address Federal laws and regulations designed to prevent fraud, waste, and abuse. Iowa intends to leverage the existing audit strategies in place for fraud and abuse detection for the incentive payment program.

While the IME employs an approach of random audits, the IME also focuses audit efforts on targeted provider categories. We believe out-of-state providers may be more likely to take advantage of the Iowa program. Also, because PAs are not currently enrolled in Medicaid, PAs also receive additional focus. Finally, smaller provider practices who do not have the advantage of an in-house compliance office may be at greater risk of not meeting all requirements for the program. As these audits yield results, the IME will continue to hone its audit strategy. In addition, audits will target providers who marginally meet patient volume requirements.

The IME's audit strategy targets five percent (5%) of providers who receive payment during any one quarter. The IME recently began auditing providers who received an A/I/U payment during the first quarter of 2011 (five EPs and one hospital).

For 2012, the IME will audit for Stage 1 Meaningful Use and clinical quality measures through requests from a provider's EHR system.

This section provides details of the existing Manage Program Integrity Case processes as defined in the MITA State Self-Assessment conducted in January 2009.

The Manage Program Integrity Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or member from the Medicaid program; or the case may be terminated or suspended. Responsibility for the process is centralized, within the Program Integrity Unit at the IME. The Medical Services Unit at the IME and the IME policy staff provide support. When a case is determined as resulting in a fraud or criminal situation, the case is turned over to either the DIA Bureau of Economic Fraud (Member) or the DIA MFCU (Provider), as appropriate. Individual state policy determines what evidence is needed to support different types of cases.

Pre-Payment Verification Areas:

Prior to issuing payment, the IME staff performs reviews based on information provided in the attestation:

- The provider is enrolled in Iowa Medicaid, if the provider is a type required to enroll in Medicaid in order to treat Medicaid patients;
- The provider has not been sanctioned;
- From a high level check of claims volume or managed care and/or medical home members, the minimum patient volume threshold is achieved during the desired 90-day period of the previous calendar year for EPs or fiscal year for eligible hospitals;
- For providers claiming incentives based on adopt, implement, upgrade, that no previous year payment was made and that the provider has adopted certified EHR technology

Provider Type	Document Type	Required at time of Attestation	Required as proof in the event of an audit
Physician Assistants working in an FQHC/RHC	License issued by Iowa Board of Physician Assistants, showing license number	Yes	Yes
Physician Assistants working in RHC that is owned by the PA	Proof of ownership of RHC	Yes	Yes
All	Proof of patient volume, including location (mailing address) of service	Optional, required	Yes
All	Copy of EHR invoice or contract	Yes	Yes
EPs assigning their payment	Proof of EP's contract or employment agreement	Yes	Yes

Providers are required to affirm that they understand they are to keep proof of all attestation requirements for a minimum of six years. In the event of a failed audit, the provider's status will be put into a credit balance to recoup the money.

Post Payment

The Program Integrity Unit will audit a subset of the payments determined by random sampling methodologies. Five percent (5%) of the A/I/U payments will be audited each year and a separate number of the payments for meaningful use will be audited for subsequent years. The existing program integrity team performs audit activities. Certain high-risk providers are also be targeted for auditing. High-risk providers and the corresponding audit strategy are provided in the table below.

Risk Category	Audit Strategy
Out-of-state providers	Verify: • Patient volume – providers will be required to supply proof to support their attestation of patient volume, including appointment books or billing statements covering their designated 90-day period. This should supply information for validating both the numerator and denominator. Providers will be required to explain their process for determining 30% of their population is attributable to Medicaid. • A/I/U or MU of certified EHR – providers will be required to supply proof of EHR adoption or upgrade, as well as proof of certification of the EHR. This will be accomplished through copies of purchase agreements and contracts. There will also be coordination with other state's Medicaid agency to verify patient volume and to document they are enrolled and in good standing with their state's Medicaid.
Physician Assistants practicing in an FQHC/RHC that is "so led" by a PA	Verify: • Proof of licensure as a PA in Iowa • Proof that the FQHC/RHC is so led by a PA, as declared in the attestation: ○ PA is the primary provider – look at appointment books and any patient assignment documentation ○ PA is the clinical or medical director – this should be documented in the business plan ○ PA is the owner of the RHC – proof of ownership • Patient volume • A/I/U or MU of certified EHR
EPs practicing predominately in an FQHC/RHC and using the "needy individual" calculation for patient volume	Verify: • Total patient volume • Medicaid patient volume • CHIP patient volume • Patients receiving uncompensated care or care on a reduced or sliding scale • A/I/U or MU of certified EHR
EPs practicing in multiple locations, some of which do not have an EHR	Verify: • Total patient volume at each site • Medicaid patient volume at each site • A/I/U or MU of certified EHR at each site
Providers who marginally meet the	Verify: • Total patient volume over the declared 90-day period

Risk Category	Audit Strategy
patient volume requirements	• Medicaid patient volume over the declared 90-day period • Verification that the same methodology was used for both the numerator and denominator
Providers who needed multiple attempts to qualify	Verify: • Total patient volume over the declared 90-day period • Medicaid patient volume over the declared 90-day period • Verification that the same methodology was used for both the numerator and denominator

Patient Volume

One of the audit categories is verification of patient volume. The IME uses a methodology for calculating patient volume that is as inclusive as possible, while balancing the administrative burden on the IME and providers and being compliant with final federal regulations. The IME understands that in order to be eligible for payments eligible professionals must have at least 30% of the practice attributable to Medicaid (or 20% in the case of pediatricians, 10% for acute care hospitals.) FQHC and RHC must attribute 30% of patient encounters over a 90-day period to "needy individuals."

For providers facing audit, because providers applying for incentives will be in various stages of EHR adoption, the approach for proving patient volume must be flexible. Providers with an existing EHR are usually able to prove patient volume with systems reports, whereas paper-based practices depend on manual calculations and patient appointment books. In selecting which 90-day period during the year to select for proving patient volume, the IME encourages providers to select a period in which they are most likely to qualify for the incentives.

Iowa accepts either one of the two methods for calculating patient volume as provided in the final rule. The first permits calculation based on the number of Medicaid encounters during any given 90-day period as selected by the provider. Iowa does have some managed care providers who manage care for patients on their panel. These providers are permitted to include in their numerator patients on their panel whom they have seen at any time in the previous calendar year, regardless of whether they were seen in the designated 90-day period. If the panel patient is also seen during the 90-day period, the provider counts the patient only one time, or for the number of times seen during the 90-day period. Providers will be required to attest that they are using the same approach in calculating the numerator as that in calculating the denominator. The IME also intends to include in the numerator patients who are covered by any of the Medicaid waiver programs.

Iowa permits clinics and group practices to use the clinic-wide Medicaid patient volume and apply it to all EPs in their practice under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology (for example, if an EP sees only Medicare, commercial, or self-pay patients, this is not an appropriate calculation
2. There is an auditable data source to support the clinic's patient volume determination and
3. So long as the practice and EPs decide to use one methodology in each year (clinics cannot have some of the EPs using their individual patient volume for patients seen at all the clinic, while others use the clinic-level data)

Iowa includes the encounters of ancillary providers such as pharmacists, educators, etc. when determining if the EPs are eligible, per patient volume requirements. If these non-EP encounters are included in the numerator, they must be included in the denominator as well. If the entire

clinic or group practice uses the entire practice or clinic's patient volume, they are not permitted to limit patient volume in any way. Likewise, if a physician's assistant (PA) provides services, but they are billed through the supervising physician, Iowa permits consideration of the patient as part of the patient volume for both professionals. This policy is applied consistently in calculating both the numerator and denominator.

While the IME has an indication of the number of Medicaid patients seen based on claims data, the total number of Medicaid patients must be supplied by the provider. To ensure accuracy and to increase the chances of meeting the threshold, the numerator will also include patients covered by other state's Medicaid, as well as the IME patients who were seen, but not billed, as a result of primary insurance coverage. Because these numbers contribute to the numerator, but will not be reflected in the IME claims, providers are required to supply these figures. The IME verifies patients covered by another state's Medicaid by contacting the other state's Medicaid agency.

The IME also includes in the numerator patients who are covered by any of the Medicaid 1115 waiver programs.

Verification Methods

Providers who already have an existing EHR may be able to supply reports that indicate the percentage of patients covered by Medicaid. Exhibit A is an example of a report depicting patient count by payer. The EHR can also create lists of patients by payer. During an audit, the IME will use these lists to identify patients enrolled in other state's Medicaid programs and will facilitate verification of enrolment with the other state.

For providers who do not have an EHR, or whose EHR does not provide adequate patient reporting, the IME will work with the providers to determine what they can submit as proof, with minimum work for the providers, but enough information for the IME to be dependable. Examples of acceptable proof include copies of schedules, or copies of claims to different pays. This proof is required only on cases the IME selects for audit.

In addition, the IME depends on the records of the FQHCs and RHCs when calculating their needy patient volume. The IME works with these facilities individually to ensure that all patients on Medicaid, CHIP, or whose fees are adjusted according to their income, are counted in their numerator. If possible, the Iowa Medicaid encounters are confirmed based upon claims paid during the qualification time period. However, due to enrollment and billing rules, this is not always the case. In cases where the IME cannot verify Medicaid patient volume, the providers are contacted to supply documentation of patient volume. The IME also has agreements with neighboring states to verify the patient volume to ensure the accuracy when providers claim patients covered by another state's Medicaid.

The IME works closely with providers to determine overall patient volume. The IME ensures that providers understand the definition of an "encounter" and that a common definition is being applied to both the numerator and denominator. When selected for an audit, as with the numerator, providers who already have an EHR may be able to supply reports that indicate

overall patient volume. The provider produces a report indicating the aggregate number of Medicaid encounters (by state if the provider serves multiple states), and the total number of patient encounters. The volume of total patient encounters is checked to ensure the number is reasonable based upon the practice type.

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4-1-2009
6-30-2009

MISYS

Insurance Company
Patient Percentage

Date: 3/17/2010
Time: 10:15AM
Page 1

Filter Used: Charge Entry

Ins#	Ins Name	Pat Count	% of Insu
1	BLUE CROSS BLUE SHIELD	361	27.33%
2	AETNA	34	2.57%
3	PRINCIPAL	49	3.71%
4	UNITED HEALTHCARE	39	2.95%
5	MIDLANDS CHOICE	60	4.54%
7	CONNECTICUT GENERAL	1	0.08%
9	INTERPLAN HEALTH GROUP	1	0.08%
19	ASSOCIATED BENEFITS	2	0.15%
21	TRICARE	13	0.98%
26	CIGNA	14	1.06%
30	CORPORATE BENEFIT SERVICE	1	0.08%
31	COVENTRY HEALTH CARE	7	0.53%
39	GREAT WEST	1	0.08%
44	MAIL HANDLERS	1	0.08%
53	SANFORD HEALTH PLAN	11	0.83%
61	FEDERATED INSURANCE	1	0.08%
64	UMR	6	0.38%
90	DAKOTACARE	11	0.83%
95	SELF INSURED SERVICE	1	0.08%
101	MEDICAID IOWA	490	37.09%
102	MEDICAID NEBRASKA	108	8.18%
103	MEDICAID SD DEPT OF SOCIAL SVC	7	0.53%
118	GOLDEN RULE	2	0.15%
124	PRIVATE PAY	18	1.36%
138	FIRST ADMINISTRATORS	56	4.24%
153	MEGA LIFE AND HEALTH	1	0.08%
156	MEDICA	2	0.15%
210	AVERA HEALTH PLANS	19	1.44%
270	ASSOCIATES FOR HEALTH CARE	1	0.08%
284	DEFINITY HEALTH CLAIMS	1	0.08%
344	PHYSICIANS PLUS INSURANCE CO	1	0.08%
348	MOUNTAIN STATES ADMINISTRATIVE	1	0.08%
357	PROGRESSIVE INSURANCE	1	0.08%
	1321 Patients		

Posting Date: 4/1/2009 - 6/30/2009
Insk 3 9999

Report: C:\Iaca\Misys\Query Workspace\4 1 09 6 30 09 RWR.lmr
Database User ID: query

Exhibit A

A/I/U

As part of an in-depth audit, the IME performs the following to verify, adopt, implement and upgrade activities around certified EHR technology:

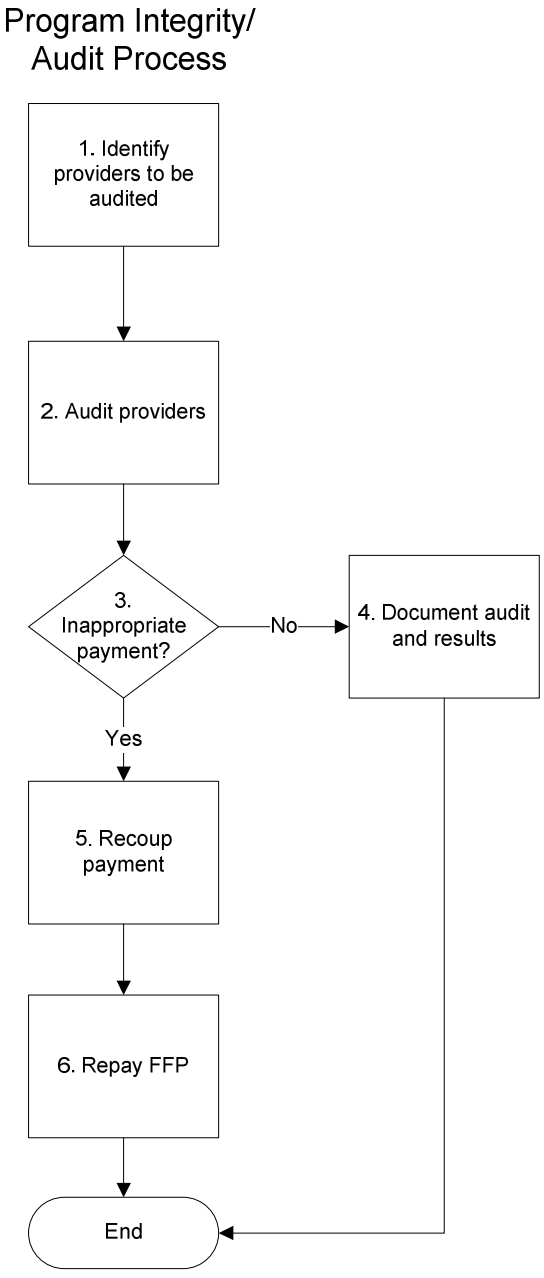
- Review the contract, purchase order, or documentation supporting A/I/U activities.
- Confirm the certification number is a certified product as per the CHPL.
- When appropriate, request an on-site visit to see the system and/or or confirm adoption activities have occurred.

Meaningful Use

Once providers begin submitting meaningful use and clinical quality measures, program integrity staff will conduct the following checks:

- Confirm that clinical quality measures have been submitted to the state and/or CMS.
- Review aggregate or statistical reports generated by the EHR confirming the measures of meaningful use (Core and selected menu measures) match those indicated via attestation. If a standard report is not available, the Program Integrity Unit will work with the provider to determine an acceptable process for verification.
- Review documentation confirming the exchange or testing of electronic health records. One operational, the HIE may be a source of verification.

Program Integrity/Audit Process Flow



Program Integrity/Audit Process Narrative

Step	Action
1	Identify providers to be audited. This will include a random, statistically valid sampling of providers who received incentive payments. There may also be systems triggers to identify providers claiming meaningful use, but who may not be using electronic claims, for example. It is also possible an audit could be triggered by a pattern of complaints from patients or other providers. Audits will begin shortly after the first payments are made. The IME will work with the provider to identify acceptable forms of proof of eligibility. If additional documentation is requested as a result of an audit, the provider will upload the documentation to IMPA.
2	Audit providers. This step includes addressing each item contained in the audit template, including verification of items on the attestation form. This step may include on-site visits to verify patient thresholds or A/I/U.
3	Inappropriate payment? If the audit reveals the incentive payment was appropriate, proceed to Step 4. Otherwise, proceed to Step 5.
4	Document audit and results.
5	Recoup payment. This step includes all tasks required for recoupment, including notice to the provider.
6	Repay FFP.

Section E: Iowa's HIT Roadmap

Overview

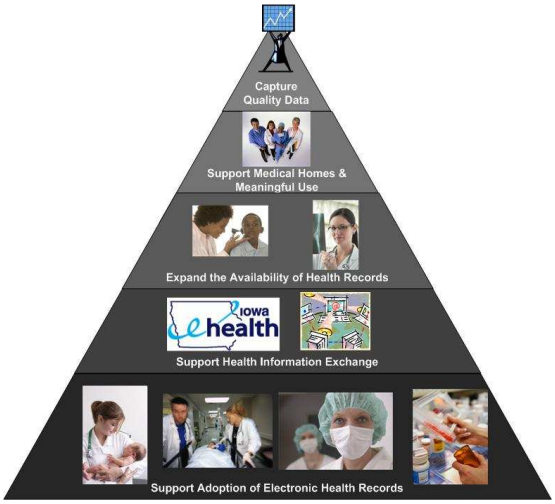
Iowa's HIT Roadmap describes the overall journey to achieving the To Be vision and EHR Incentive payments – with the appropriate milestones for achievement.

Description of Journey

Iowa's 2011 SMHP focuses on improving communication among Iowa's Health Care Providers thereby improving the quality and efficiency of care received by all Iowans.

The five major components of Iowa's HIT Roadmap:

- Support the Adoption of Electronic Health Records
- Support Health Information Exchange
- Expand the Availability of Health Records
- Support Medical Homes and Meaningful Use of Exchanged Information
- Capture Quality Measures Data



Support the Adoption of Electronic Health Records

Advances these "to-be" goals:

- *Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE)*
- *Improve Administrative Efficiencies and Contain Costs*
- *Improve Quality Outcomes for Members*
- *Improve Member Wellness*

The foundation of a more efficient healthcare delivery system starts with Iowa's providers and their adoption of Electronic Health Records.

Administer Medicaid EHR Incentive Payment

The IME implemented the appropriate EHR incentive payment systems. As discussed in Sections C & D, above, the incentive payment processing workflow will be upgraded to capture the Stage 1 meaningful use measures required by the final rule.

Design for these changes is underway and is expected to be in place by April 1, 2012 when EPs may begin applying for year two incentive payments.

Project schedule:

Deliverable	Start Date	Finish Date
Submit Updated SMHP for CMS Approval	07/15/2011	08/15/2011
Submit IAPD for CMS Approval	07/15/2011	08/15/2011
Conduct EHR Incentive Payment Outreach	Ongoing	12/31/2016
Test Meaningful Use Attestations	11/01/2011	12/31/2011
Accept Provider & Hospital Year Two Attestations	04/01/2012	12/31/2021
Audit Provider & Hospital Attestations	07/01/2011	12/31/2021
Issue Provider & Hospital EHR Incentive Payments	01/19/2011	12/31/2021

Fill EHR Technical Assistance Gaps

The IME, in cooperation with the IDPH and the HIT REC, actively monitor provider EHR adoption and research barriers to EHR adoption. The IME, IDPH, and the HIT REC will then evaluate what potential solutions exist to alleviate those barriers.

Examples of barriers currently cited by providers which will likely require coordinated efforts to solve would include: technical assistance in product selection and implementation, training for meaningful use, on-site IT support, reliable broadband connectivity, provider staff training, etc.

The IME will seek opportunities to eliminate the barriers and assist providers in the adoption and meaningful use of electronic health records.

Iowa Medicaid looks to expand technical assistance beyond providers identified within the EHR incentive programs, to key providers in the Medicaid network that would benefit from the adoption of EHR. Examples include long term care providers and behavioral health. Sharing electronic health information between these providers and

physician and hospital settings will help the IME achieve their goals of reducing hospital re-admissions and provide higher quality care.

The Iowa Department of Public Health issued a Request For Information to review technical assistance options. The results are expected to be available in July 2011. The IME plans to review alternatives and develop a plan for future implementation that coordinates and aligns with the e-Health initiatives, and with the Iowa HIT REC efforts. The technical assistance proposal will be submitted to CMS for approval via an update to the Implementation Advanced Planning Document.

IME EHR Administrative Support

The IME plans to support provider's investment in EHR technologies through the creation and formatting of the IME coverage information that works within EHR workflows. Examples could include providing formulary information that would natively work with an EHR's ePrescribing module, supporting prior authorization reminders through decision support workflows, etc.

Support Health Information Exchange

Advances these "to-be" goals:

- *Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE)*
- *Improve Administrative Efficiencies and Contain Costs*
- *Improve Quality Outcomes for Members*
- *Improve Member Wellness*

As Iowa's providers adopt EHR Technology, the IME must support the creation of Iowa's Health Information Exchange.

Continued Collaboration on EHR/HIE Adoption

The IME is a member of the Iowa e-Health Advisory Council, and actively participates in the security, governance, finance, continuity of care, infrastructure, communications and outreach, assessment, and privacy and security work groups.

The IME, IDPH and HIT REC meet monthly to ensure that the efforts of the three organizations are aligned and collaborative. The IME has committed dedicated staff to ensure that these relationships continue.

Financial Support of Iowa's HIE

The IME will support the creation and ongoing operational costs of a state-wide HIE to the extent that it supports the Medicaid population. Iowa also considered the optional solution of developing a Medicaid-only HIE as part of our Medicaid Management Information Systems. After careful consideration, Iowa feels the state and federal dollars would be more beneficial to our providers and the overall population by pooling the Medicaid efforts with a solution that also serves Medicare, VA, private insurance, and private payers.

Iowa e-Health has secured a vendor to create a financial business model for long term support of the Iowa e-Health HIE. Although the financial model is not yet finalized for both the development and sustainability of the HIE, the IME is asking CMS to support the Iowa HIE as an alternative to a Medicaid specific solution.

In 2010, 18% of Iowans receive some form of Medicaid benefits. In 2014, Health Care Reform is expected to change the number of Iowans receiving Medicaid benefits as high as 24% of the Iowa population. Iowa Medicaid anticipates investing funds to support 21% of the cost of the core functionality of the HIE over a time period of a four year build period. The core functionality includes:

- Provider Directory
- Master patient index
- Record Locater Service
- Authentication, Access and Authorization Management
- Patient Consent tracking
- Auditing and logging
- Data Security
- Direct connections to EHR
- Provider portal for viewing access for providers without and EHR
- Secure provider to provider messaging
- Connection to the NWHIN

Support HIE Enabled Communications and Services

As Iowa invests in our HIE infrastructure, the IME must make sure that the IME policies and procedures are modified, where needed, to allow providers and members to communicate with the IME via the HIE. Specifically, procedures within Prior Authorization and Program Integrity will be evaluated for compatibility with HIE communication paths.

Expand the Availability of Health Records

Advances these "to-be" goals:

- *Improve Administrative Efficiencies and Contain Costs*
- *Improve Quality Outcomes for Members*
- *Improve Member Wellness*

Provide Web Portal Access to Health Information

The IME will increase access to appropriate clinical information concerning our members through the development and deployment of a web portal. The IME believes that higher quality health care is achieved by sharing information between all care providers. Improved care contains costs and improves member wellness.

The portal would serve as a tool for sharing health information collected from multiple sources.

The web portal functionality would be used by:

- Medicaid Staff – for use in Prior Authorization, Program Integrity, EHR Incentive Payment Processing, and related functions. The portal would connect to the HIE to provide access to medical records from providers, eliminating the need for information to be sent via physical mail or faxing.
- Long Term Care & Home Health organizations – for use in utilizing Continuity of Care and Discharge Instructions from hospitals and providers.
- Medicaid members - as an electronic personal health record. This portal would provide the opportunity to distribute wellness education, and alerts/reminders for preventative care and disease management.
- Care Teams – The portal could be expanded to additional people in the care management team of the member, such as school nurses, social workers, care coordinators, foster parents, and others as determined necessary.

Authorization to access information would be role based and limited to the appropriate information for the appropriate role. Significant work will be required to establish the correct policies, rules, and, as needed, laws to insure the secured, authorized, and correct access to this information.

In FY12 the IME plans to continue to plan for the utilization of the Health Information Exchange web portal and work with the e-Health workgroups to establish the appropriate participation agreements and authorization roles.

Support Medical Home/Health Home and Meaningful Use of Exchanged Information

Advances these "to-be" goals:

- *Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE)*
- *Improve Administrative Efficiencies and Contain Costs*

- *Improve Quality Outcomes for Members*
- *Improve Member Wellness*

Establish Iowa's Medical Home/Health Home Initiative

The IME began a medical home initiative on October 1, 2010. The provider set includes the IowaCare providers and serves as a pilot to establish a model that can be expanded to other providers throughout the state.

Components of the IowaCare Medical Home/Health Home include the following:

1. Have National Committee for Quality Assurance (NCQA) Level 1 certification, or other national equivalent measurement within 18 months.
2. Provide provider-directed care coordination of services.
3. Provide members with access to health care and information.
4. Provide wellness and disease prevention services.
5. Create and maintain chronic disease information in a searchable disease registry.
6. Demonstrate evidence of implementation of an electronic health record system.
7. Participate in and report on quality improvement measures.

The IME, through participation of the IowaCare providers, have established the policies, procedures, and necessary systems to support the IowaCare medical home pilot.

Iowa is developing a State Plan Amendment option under Section 2703 of the Affordable Care Act to implement a statewide health home program for Medicaid members with qualifying chronic conditions. The health home program components are similar to the IowaCare Medical Home stated above which follows the seven principles of a patient-centered medical home. The program has a strong emphasis on comprehensive care coordination and use of the statewide HIE.

Support the IowaCare HIE Pilot

Iowa has an 1115 demonstration waiver to cover uninsured adults aged 19-64 with income at or below 200% of the federal poverty level. As part of this demonstration, Iowa is required to increase the adoption and meaningful use of EHRs and HIE by the primary network providers.

From the inception of IowaCare until July 2010, the program had only two provider systems, Broadlawns Medical Center (BMC) in Des Moines and the University of Iowa Hospitals and Clinics (UIHC) in Iowa City. Specialty care is provided by the University of Iowa in the event the specialty service is not provided at Broadlawns.

On September 1, 2010, CMS awarded Iowa an extension of the IowaCare section 1115 demonstration with authority to expand the IowaCare provider network to include Federally Qualified Health Centers (FQHCs) beginning October 1, 2010. In March 2010, Iowa's legislature in SF 2356 expanded the existing IowaCare provider network to include FQHCs effective October 1, 2010. FQHCs participation in IowaCare is phased-in and based upon addressing the most underserved areas of the state. The new legislation also authorized the use of the medical home model for this population.

One of the greatest challenges in serving this population has been the communication between the primary care physician and the specialty service providers. Patients are often subjected to duplicate testing at both the primary care and specialist settings. Communication between settings can be problematic, leading to member confusion on care instructions.

The IME has taken steps to accelerate the electronic exchange of information among these provider groups.

In the absence of a statewide HIE, Broadlawns and UHIC proceeded with building a secure exchange of provider referrals, continuity of care, and discharge information. This effort has been a very effective communication tool. The Federally Qualified Health Care clinics have not yet been able to share information electronically with the UIHC. This was very challenging for the FQHCs as patients transitioned to medical homes closer to their community.

Taking lessons learned from the IowaCare Medical Home pilot, Iowa is developing a State Plan Amendment option under Section 2703 of the Affordable Care Act to implement a statewide health home program for Medicaid members with qualifying chronic conditions. The health home program components are similar to the IowaCare Medical Home stated above which follows the seven principles of a patient-centered medical home. The program has a strong emphasis on comprehensive care coordination and use of the statewide HIE.

Participating providers will be required to connect to the statewide HIE as a mechanism to report quality measures to the state and to provide a network of health information that will support care coordination activities.

Iowa's health home program will begin enrolling providers in early 2012 while the implementation to report quality measures is slated to begin in July 2012.

Improve Clinical Information Access at Transitions of Care

Hospital and Nursing Home re-admission rates contribute to a large portion of healthcare costs. A recent study showed that Medicare Members Inpatient charges

accounted for 31% of all Medicare costs and that 18% of Medicare patients who were in a hospital are re-admitted to the hospital within 30 days.

http://www.academyhealth.org/files/publications/Reducing_Hospital_Readmissions.pdf

The IME will help decrease readmission rates between provider settings by supporting the use of the HIE for the exchange of continuity of care and discharge information among care teams (members, guardians, long term care providers, home health providers, etc) as determined appropriate. Iowa anticipates significant legal research and potential legislation changes will be needed to ensure patient privacy and medical record security.

This remains a goal of the IME. As of July 2011, the IME has been limited in making progress on this goal by the delay in the build of the Iowa e-Health Health Information Exchange. The Iowa e-Health has received applications from twenty (20) long term care facilities and seven (7) health home agencies indicating an interest in participating in the exchange.

Capture Quality Measures Data

Advances these "to-be" goals:

- *Improve Administrative Efficiencies and Contain Costs*
- *Improve Quality Outcomes for Members*
- *Improve Member Wellness*

A requirement of the meaningful use of electronic health records is that providers will capture a minimum of 6 clinical quality measures from a menu of 44 options. The provider must submit the results of the measures to CMS and to the Iowa Medicaid Enterprise.

It is the IME's hope that while the rules do not require providers to report all clinical quality measures, providers will choose to report beyond the minimal number of measures as their EHR allows.

Receive Quality Measures Data

The IME has identified a solution to capture quality measures for meaningful use through the Iowa Health Information Exchange. Providers who are connected to the HIE will be able to publish their metrics directly to the Iowa Medicaid solution.

In addition to providing data for verification of meaningful use, the tool will allow the IME to support pay for performance for Health Home programs and potentially confirm quality performance for future Accountable Care Organizations (ACOs).

Deliver Education and Interventions

Based on trends indentified within the capture of quality metrics, The IME will look for opportunities to improve the care members receive through provider education. This education would include information on Quality Measures, the associated standards of care members should receive, and EHR usage best practices.

The IME anticipates FY 2012 will be a year of learning about the availability of metrics and how to interpret the data. Education and Intervention are longer term goals for SFY 2014 and SFY 2015.

Strategies

The information below, is the high level (a.k.a. Vision Level) planning and estimating which has been performed to date. The IME expects that the individual IAPD line items will

include the required implementation level planning and estimates for the deliverables described above.

SFY 2011

Support Adoption of EHR	Action	Status
	Administer the EHR Incentive Program - Provider	Ongoing
	Administer the EHR Incentive Program - Hospital	Ongoing
	Administer the EHR Incentive Program - Systems Development	Ongoing to support MU. New system procurement planned
	Administer the EHR Incentive Program – Processing	Ongoing
	Support Provider outreach and education on the Incentive Program, HIT REC and HIE	Ongoing
	Modify Provider Re-Enrollment/Enrollment to include EHR survey and outreach	Moved to SFY 2012
Support Health Information Exchange	Provide funding support for the planning and implementation of the statewide HIE.	Ongoing
	Participate in the planning and creation of a statewide health information exchange. Iowa e-Health, led by the Iowa Department of Public Health and under the direction of the e-Health Executive Committee and Advisory Council. The Iowa Medicaid Enterprise (IME) will participate in the Executive Committee, Advisory Council and workgroups to ensure the unique needs of the Medicaid population and Medicaid program are considered.	Ongoing
Expand the Availability of Health Records	Acquire Electronic Health Records Web Portal. Build foundation for access to HIE by Medicaid administration, and plan for additional access.	Moved to SFY 2012
Support Medical Home & Meaningful Use	Support the exchange of information between the Medical Home, Health Homes, and specialty care providers.	The HIT staff participated in numerous planning meetings. State Plan amendment and rules are expected to be approved in SFY12.

Capture Quality Data	Create mechanism for the receipt, data warehousing, and reporting of Quality Measure information	DDI moved to SFY12
HIT Program Administration	Overall Coordination of HIT Efforts	Ongoing
	Participation in Multi-State collaboratives and the communities of practice.	Iowa was an active participant in multi-state communication efforts.
	Continuing opportunities for education (both learning and sharing)	Iowa participated in the following conferences as either an attendee or speaker: MMIS, CMS HITECH, HIMSS, ONC Grantee meetings, and Medicaid Congress

SFY12	Action
Support Adoption of EHR	Continue to administer the EHR Incentive Program.
	Upgrade the EHR administration tool to include attestation for meaningful use Stage 1.
	Modify Provider Re-Enrollment/Enrollment to include EHR survey and outreach.
	Create a plan to provide technical assistance to providers who do not qualify for HITREC support for the adoption and meaningful use of EHR. Targeted providers would include labs, long-term care, mental health and substance abuse providers.
	Co-sponsor the Iowa e-Health Summit to motivate Iowa providers to adopt electronic health records. The summit will focus on adopt, implementation, upgrades, meaningful use, health information exchange, and Medicaid vision for health home and the use of HIT.
Support Health Information Exchange	Development and Operational Support of HIE.
	Provide technical and financial assistance to support connectivity between public health reporting systems and the HIE. Provide technical assistance to support connectivity between key lab and imaging facilities and the HIE.
Expand the Availability of Health Records	Acquire Electronic Health Records Web Portal. Build foundation for access to HIE by Medicaid administration, and plan for additional access.
	Expand functionality of the Web portal. Program support for privacy and security issue resolution and creation of operations processes.
	Provide Medicaid access to clinical data through the HIE for the purposes of pre- and post-pay medical review and level of care determination.
	Plan for use cases for access to the Web Portal for the Medicaid Member's care team (Guardians, parents, foster parents, social workers, school nurses, case managers, care managers, etc.).
Support Medical Home & Meaningful Use	Provide Formulary information in a format which providers can "import" into their EHRs.
Capture Quality Data	Quality Measure System – DDI.

SFY13	Action
Support Adoption of EHR	Continue to administer the EHR Incentive Program.
	Prepare attestation and program administration for meaningful use stage 2.
	Evaluate and assess the success and progress of the EHR incentive program and Medicaid provider's use of electronic health records.
	Provide technical assistance to providers to transition to the meaningful use of electronic health records.
Support Health Information Exchange	Participate in council and workgroup meetings of the e-Health project.
	Provide technical and financial assistance to support connectivity between public health reporting systems and the HIE.
Expand the Availability of Health Records	Continue to expand the usage of the Web Portal to members of the care team.
	Plan for integration of personal health records and quality alert messages to Medicaid Members.
	Provide access to clinical data through the HIE for the purposes of disability determination services.
Support Medical Home & Meaningful Use	Review the rules for Medical and Health home and update as appropriate to increase the meaningful use of EHR.
Capture Quality Data	Analyze quality data looking for performance and education opportunities.

SFY14	Action
Support Adoption of EHR	Continue to administer the EHR Incentive Program.
	Prepare attestation and program administration for meaningful use stage 2.
	Evaluate and assess the success and progress of the EHR incentive program and Medicaid provider's use of electronic health records.
	Provide technical assistance to providers to transition to the meaningful use of electronic health records.
Support Health Information Exchange	Participate in council and workgroup meetings of the e-Health project.
	Provide technical and financial assistance to support connectivity between public health reporting systems and the HIE.
Expand the Availability of Health Records	Continue to expand the usage of the Web Portal to members of the care team.
	Plan for integration of personal health records and quality alert messages to Medicaid Members.
Support Medical Home & Meaningful Use	Review the rules for Medical and Health home and update as appropriate to increase the meaningful use of EHR.
Capture Quality Data	Analyze quality data looking for performance and education opportunities.

SFY15	Action
Support Adoption of EHR	Continue to administer the EHR Incentive Program.
	Prepare attestation and program administration for meaningful use stage 3.
	Evaluate and assess the success and progress of the EHR incentive program and Medicaid provider's use of electronic health records.
	Provide technical assistance to providers to transition to the meaningful use of electronic health records.
Support Health Information Exchange	Participate in council and workgroup meetings of the e-Health project.
	Final year of financial assistance for the "build" of the core Health Information Exchange Services.
Expand the Availability of Health Records	Promote the personal health records portal to members, and where appropriate parents, to encourage personal responsibility toward health care.
	Expand quality alert messages to Medicaid Members through the personal health records portal.
Support Medical Home & Meaningful Use	Review the rules for Medical and Health home and update as appropriate to increase the meaningful use of EHR.
Capture Quality Data	Analyze quality data looking for performance and education opportunities.

Progress Tracking & Audit and Oversight

The IME's HIT Coordinator is accountable for tracking overall progress of the IME's SMHP and the submission of the Implementation Advance Planning Document (IAPD). Within the SHMP/HIT IAPD, the IME describes the project tracking methodology required for individual project completion.

The IME will also revise this SMHP on an annual basis to describe progress and continue to align the IME's vision with industry trends, adoption cycles, and applicable legislation.

Appendices

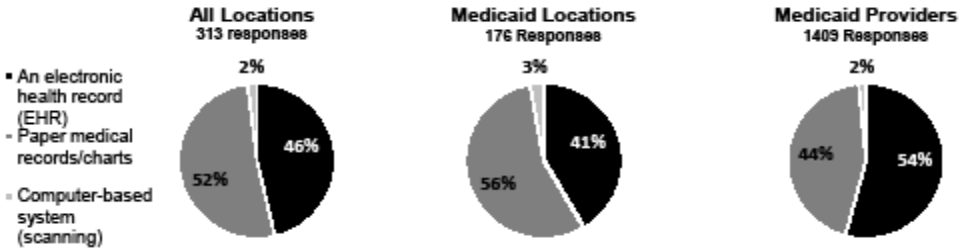
Appendix A – Physician Practice Survey

See below

Analysis of Medicaid Providers
Further Understanding the Health IT Landscape in Iowa

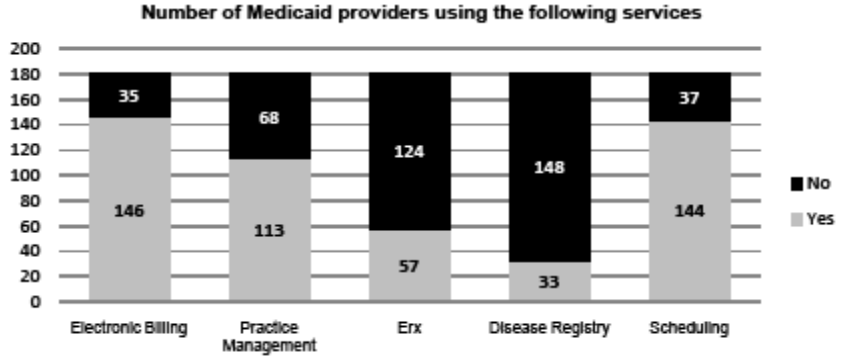
The following information represents a summary of data from an ambulatory practices/clinic assessment conducted by Iowa e-Health between December 2009 and January 2010.

1. EHR status among ambulatory practices and clinics in Iowa:

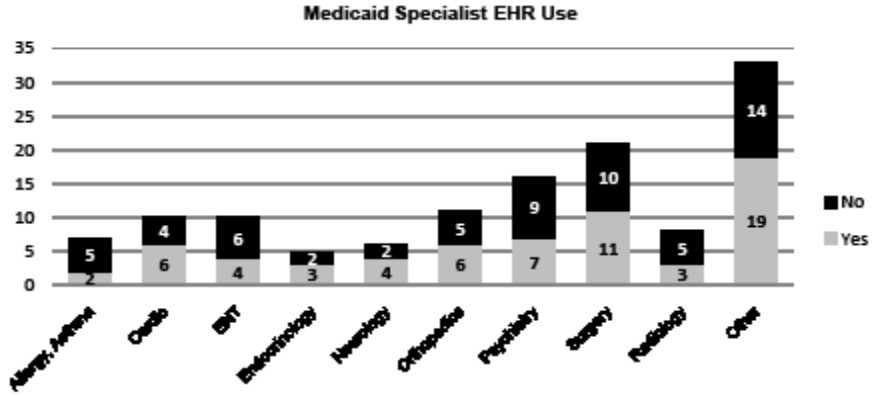


Response to the question: Do you currently use an EHR?

2. Types of EHR services used among Medicaid providers:



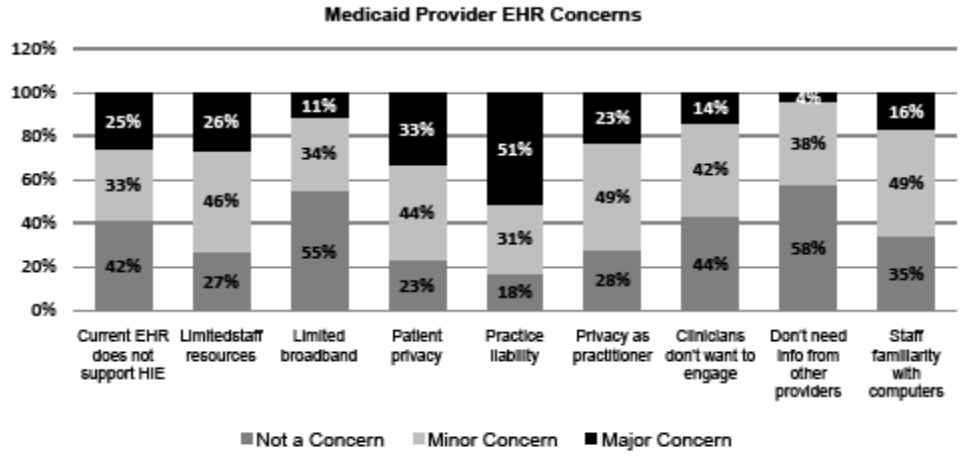
3. **Medicaid providers that use an EHR system by their specialty:**



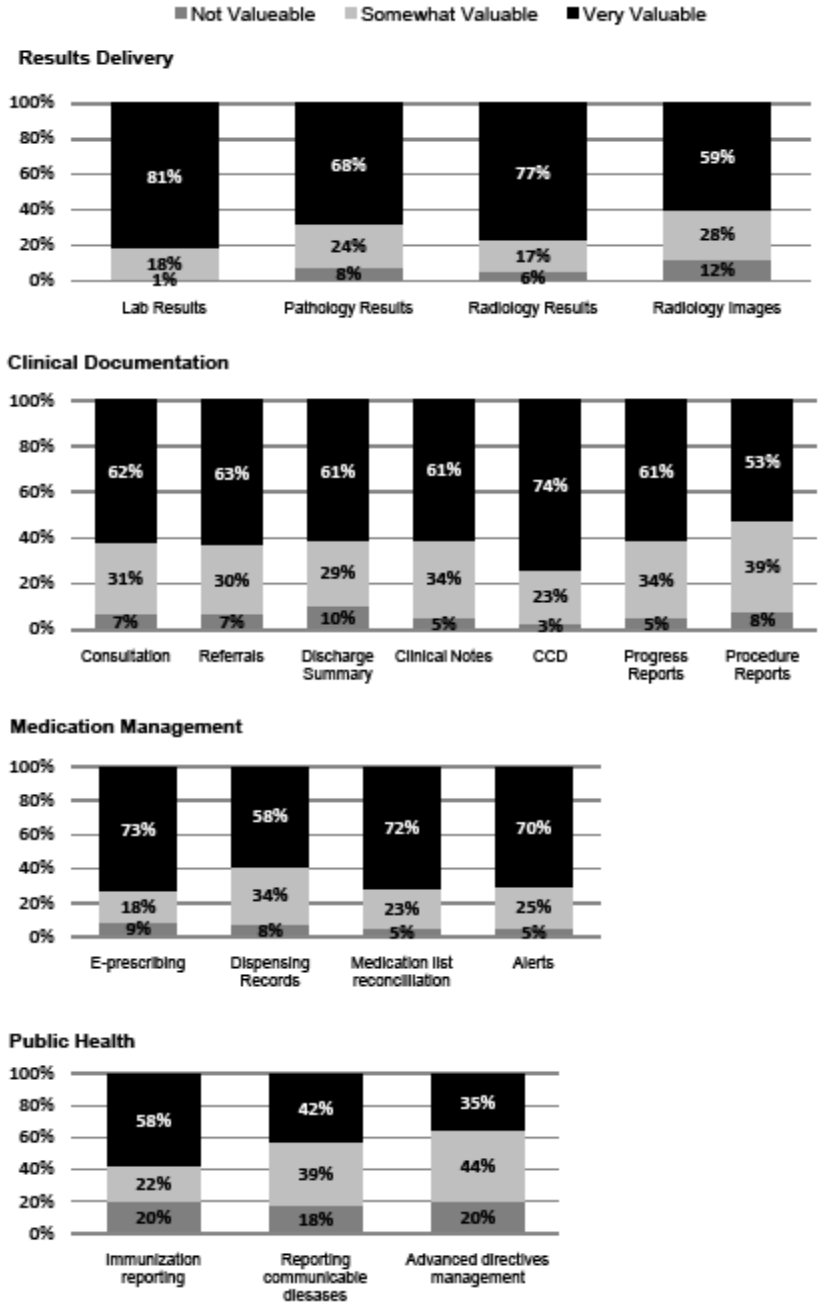
4. **Common certified or previously certified EHR vendors in use by Medicare providers.**

- Allscripts
- Cerner
- CPSI
- GE Healthcare
- Healthland
- LSS Data Systems
- McKesson
- NextGen
- Sage

5. **Concerns about adopting EHRs among Medicaid providers.**

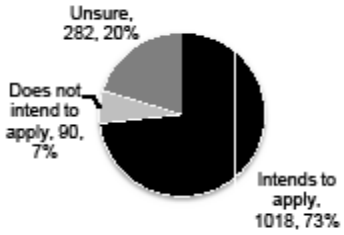


6. **Value of various types of clinical data exchange through a health information exchange.**

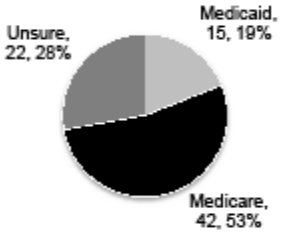


7a. Ambulatory practices/clinics intending to apply for meaningful use provider incentives available through Medicare and Medicaid:
(Intention, number of responses, percentage)

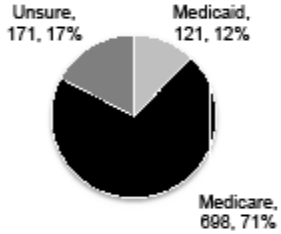
7b. Ambulatory practitioners intending to apply for meaningful use provider incentives available through Medicare and Medicaid:
(Intention, number of responses, percentage)



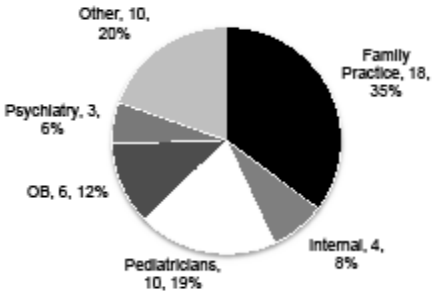
8a. Of those practices interested in meaningful use incentives, the source from which they intend to seek funding:
(Intention, number of responses, percentage)



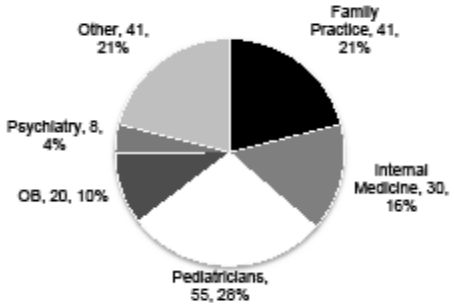
8b. Of those practitioners interested in meaningful use incentives, the source from which they intend to seek funding:
(Intention, number of responses, percentage)



9a. Interest in Medicaid Funding by Practice Type
(Practice type, number of locations expressing interest, percent in relation to all respondents)



9b. Interest in Medicaid Funding by Practice Type
(Practice type, number of practitioners expressing interest, percent in relation to all respondents)



For additional assessment results (not specific to Medicaid providers), see Appendix I of the Strategic and Operational Plan (http://www.idph.state.ia.us/ehealth/reports.asp).

Appendix B – Project Growth of Iowa Medicaid Programs

Total Impact:

Medicaid Eligibility --
All Categories

	Actual				Projected										
	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	' 2020
Regular Medicaid	296,451	296,797	305,941	330,286	361,390	372,232	383,399	394,901	406,748	418,950	431,519	444,464	457,798	471,532	5,678
Expansion to 138% FPL	0	0	0	0	0	0	0	0	88,102	89,816	91,565	93,347	95,165	97,019	,909
IowaCare	12,249	16,001	20,547	27,292	33,622	34,631	35,670	36,740	26,260	27,048	27,859	28,695	29,556	30,443	,356
Family Planning Waiver	3,792	20,373	20,972	23,402	23,739	24,451	25,185	25,940	26,718	27,520	28,346	29,196	30,072	30,974	,903
Medicaid Expansion	11,768	12,228	12,186	13,419	14,938	15,386	15,848	16,323	16,813	17,317	17,837	18,372	18,923	19,491	),075
Total	**324,260**	**345,399**	**359,646**	**394,399**	**433,689**	**446,700**	**460,101**	**473,904**	**564,641**	**580,651**	**597,125**	**614,074**	**631,514**	**649,458**	**7,921**

Appendix C – Summary Results from the 2009 MITA Self Assessment

Table 1 Alignment of the IME Priorities with MITA Goals

MITA Goals							
IME's Priorities		(3) Promote an enterprise view	(2) Promote flexibility, adaptability, and changeability	(5) Provide performance metrics	(4) Provide timely, accurate, usable and accessible data	(1) Develop integrated systems	(6) Coordination with other partners
	Number of Priorities Matching a Goal	*8*	*7*	*7*	*6*	*4*	*4*
	1. Improved Web-based options for stakeholders		■		■	■	■
	2. Automated verification/credentialing	■			■	■	■
	3. Monitor contractor performance			■			
	4. Strategic Management	■	■	■			
	5. Training in program analysis	■	■	■			
	6. Medicaid Value Management			■			
	7. Improve data analysis – access, tools, resources	■			■		
	8. Improve member services						■
	9. Modular approach to replacing system functionality		■			■	
	10. Expansion of document management and workflow management capabilities	■			■	■	
	11. Improving waiver programs				■		
	12. Rules-based engine		■		■		
	13. Standardization of data and reports						
	14. Credentialed as a MCO						
	15. Expand Care Management	■					■
	16. Self-audit of Program Integrity			■			
	17. Program Integrity in every unit	■		■			
	18. Shifting the focus of Policy unit	■	■				
	19. Ongoing evaluation of Prior Authorization		■	■			

Table 2 As-Is Maturity Level Assessment at the Business Area Level

Business Area Name	Maturity Level Summary
Member Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 12.5% level 1 – 7 BPs – 87.5%
Provider Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 14.29% level 1 – 6 BPs – 85.71%
Contractor Management	This area as a whole is currently at level 1. The business processes within this area are at the following levels: level 2 – 1 BPs – 1.11% level 1 – 8 BPs – 88.89%
Operations Management	This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 12 BPs –46.15% level 1 – 13 BPs –53.85% Note: There are 26 Operations Management business processes, but one of these is not currently a part of the Iowa MITA Enterprise.
Program Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 4 BPs – 20% level 1 – 16 BPs – 80%
Business Relationship Management	This area has 4 BPs, all at level one level 1 – 4 BPs – 100%

Business Area Name	Maturity Level Summary
Program Integrity Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 50% level 1 – 1 BPs – 50%
Care Management	This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 2 BPs – 66.67% level 1 – 1 BPs – 33.33% Note: There are four Care Management business processes but one of them is not currently a part of the Iowa MITA Enterprise.

Table 3 As-Is Maturity Assessment at the Technical Area Level

Technical Area	Maturity Level Summary
Business Enabling Services	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 5 – 45.45% level 1 – 6 – 54.55%
Access Channels	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Interoperability	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 20% level 1 – 4 – 80%
Data Management and Sharing	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Performance Measurement	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1– 50% level 1 – 1– 50%
Security and Privacy	This area is currently at level one IME does not currently perform one technical process , Intrusion Detection The technical functions within this area are at the following levels: level 2 – 3 – 60% level 1 – 2 – 40%
Flexibility – Adaptability and Extensibility	This area is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 25% level 1 – 3 – 75%

Table 4 As-Is Maturity Level Assessment at the Business Area Level

Business Area Name	Maturity Level Summary
Member Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 12.5% level 1 – 7 BPs – 87.5%
Provider Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 14.29% level 1 – 6 BPs – 85.71%
Contractor Management	This area as a whole is currently at level 1. The business processes within this area are at the following levels: level 2 – 1 BPs – 1.11% level 1 – 8 BPs – 88.89%
Operations Management	This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 12 BPs –46.15% level 1 – 13 BPs –53.85% Note: There are 26 Operations Management business processes, but one of these is not currently a part of the Iowa MITA Enterprise.
Program Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 4 BPs – 20% level 1 – 16 BPs – 80%
Business Relationship Management	This area has 4 BPs, all at level one level 1 – 4 BPs – 100%

Business Area Name	Maturity Level Summary
Program Integrity Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 50% level 1 – 1 BPs – 50%
Care Management	This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 2 BPs – 66.67% level 1 – 1 BPs – 33.33% Note: There are four Care Management business processes but one of them is not currently a part of the Iowa MITA Enterprise.

Table 5 As-Is Maturity Assessment at the Technical Area Level

Technical Area	Maturity Level Summary
Business Enabling Services	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 5 – 45.45% level 1 – 6 – 54.55%
Access Channels	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Interoperability	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 20% level 1 – 4 – 80%
Data Management and Sharing	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Performance Measurement	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1– 50% level 1 – 1– 50%
Security and Privacy	This area is currently at level one IME does not currently perform one technical process , Intrusion Detection The technical functions within this area are at the following levels: level 2 – 3 – 60% level 1 – 2 – 40%
Flexibility – Adaptability and Extensibility	This area is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 25% level 1 – 3 – 75%

Appendix D – Hospital EHR Incentive Worksheet

Iowa Medicaid Enterprise

Medicaid EHR Incentive Hospital Estimation Worksheet

Medicaid EHR Hospital Incentive Worksheet <Hospital Name> <Hospital NPI>

The overall "EHR" amount is the sum over 4 years of (a) the base amount of $2,000,000 plus (b) the discharge related amount defined as $200 for the 1,150 through the 23,000 discharge for the first payment year then a pro-rated amount of 75% in yr 2, 50% in yr 3, and 25% in yr 4

For years 2-4 the rate of growth is assumed to be the previous 3 years' average.

Step 1: Compute the average annual growth rate over 3 years using previous Medicare cost reports.

Per the Medicare cost report, worksheet S-3, part I, line 12, column 15 - Total discharges

Fiscal Year 2007		2,291		
Fiscal Year 2008	2,291	2,131	(160)	-6.98%
Fiscal Year 2009	2,131	2,083	(48)	-2.25%
Fiscal Year 2010	2,083	1,932	(151)	-7.25%
	Total % Inc 2005-2009 Divide by 3 years			-16.5% 3
The average annual growth rate over 3 years				-5.50%

Step 2:	Compute total discharge related amount using proper transition factors > discharges are capped at 23,000 each year						
	FY 2010 total Discharges from worksheet S-3, part I, line 12, column 15						1,932
	Year 1	(allowed dischg - 1,149) x $200	156,600		allowd dischg		1,932
	Year 2	((allowed dischg - 1,149) x $200)	135,400		allowd dischg		1,826
	Year 3	((allowed dischg - 1,149) x $200)	115,400		allowd dischg		1,726
	Year 4	((allowed dischg - 1,149) x $200)	96,400		allowd dischg		1,631
	Total 4 year discharge related amount	503,800					

Step 3:	Compute the initial amount for 4 years	Year 1	Year 2	Year 3	Year 4
	Years 1 - 4 base amount of $2,000,000 per year	2,000,000	2,000,000	2,000,000	2,000,000
	Years 1-4 discharge related amount (step 2)	156,600	135,400	115,400	96,400
Step 4:	Aggregate EHR amount for 4 years *Medicare Share Set at 1 Apply Transition Factor	2,156,600	1,601,550	1,057,700	524,100
Step 5:	Compute the overall EHR amount for 4 years	5,339,950			

Step 8:	Computation of Medicaid EHR incentive amount by year		
	Year One payment = 40%	$	226,414
	Year Two payment = 40%	$	226,414
	Year Three payment = 20%	$	113,207

Appendix E –Final Iowa Administrative Rule

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) *State elections.* In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:
a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is "hospital-based" for purposes of the regulation.
b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:
(1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or
(2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.
c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.
d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.

79.16(2) *Eligible providers.* To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:
a. The provider must be currently enrolled as an Iowa Medicaid provider.
b. The provider must be one of the following:
(1) An eligible professional, listed as:
1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.
(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.
c. For the year for which the provider is applying for an incentive payment:
(1) An acute care hospital must have 10 percent Medicaid patient volume.
(2) An eligible professional must have at least 30 percent of the professional's patient volume covered by Medicaid, except that:
1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.
2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS).CMS will notify the department of an eligible provider's application for the incentive payment.
a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa Medicaid portal access (IMPA) Web site at https://secureapp.dhs.state.ia.us/impa/. The applicant shall use the Web site to:
(1) Attest to the applicant's qualifications to receive the incentive payment, and
(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.
b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.
c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.
a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.
b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:
(1) Eligibility,
(2) Purchase of certified electronic health record technology, and
(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

Appendix F – Provider EHR Agreements

IOWA DEPARTMENT OF HUMAN SERVICES
IOWA MEDICAID ENTERPRISE

Iowa Electronic Health Record
Incentive Program Provider Agreement

Eligible professionals complete Section I, eligible hospitals complete Section II.

I. Eligible Professionals

a. I am an eligible professional based on the following provider type (select one)
   i. Physician
   ii. Nurse Practitioner
   iii. Dentist
   iv. Certified Nurse Midwife
   v. Physicians Assistant practicing predominately in a Federally Qualified Health Center or Rural Health Clinic that is so led by a Physician Assistant (PA)

b. I am currently enrolled in Iowa Medicaid and have no sanctions pending against me. (select one) Yes or No

c. I am a Physician Assistant (PA) practicing predominately in a Federally Qualified Health Center or Rural Health Clinic that is so led by a PA (select one) Yes or No
   i. I am currently seeing Medicaid patients billed through my supervising physician. (select one) Yes or No
   ii. My supervising physician is enrolled in Medicaid and the billing National Provider Identifier (NPI) is (_____)
   iii. Indicate whether you practice predominately in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
      1. If you answered RHC, how is your clinic "so led" by a Physician Assistant (PA)? (choose all that apply): 1) A PA is the primary provider in the clinic 2) a PA is the clinical or medical director in the facility 3) A PA is the owner of the RHC
      2. Enter your license number. Note: You will be required to upload a copy of your license at the end of this attestation.

d. Provide the NPI of the organization through which you bill (e.g., if working at an FQHC, provide the NPI the FQHC uses to bill the IME)
e. I am not hospital-based. (select one) Yes or No
f. What percentage of your patients are seen in a hospital setting (ED or inpatient)?
g. I am applying for incentives because I have adopted, implemented or upgraded to certified electronic health record (EHR) technology.
    i. 1) Adopted 2) Implemented 3) Upgraded
h. The certification number of my certified EHR is ___

To complete this section, please complete the appropriate sections of the Payment Justification Worksheet, found at http://www.ime.state.ia.us/docs/CalculatingEPcontributionsworksheet..pdf

i. What is your total, individual cost of the EHR, including original purchase amount, hardware, connectivity, training, etc. (line 8 of Worksheet 1, Section 1)
j. I have not received State or local government contribution to funding that is directly attributable to the cost of the EHR technology. (select one) Yes or No
k. I have spent at least $3750 on the adoption, implementation or upgrade to certified EHR technology. (select one) Yes or No
l. This amount was spent on the following: (choose all that apply):
    i. Hardware costs
    ii. Software costs
    iii. Staff training
    iv. Maintenance fees
    v. Connectivity
    vi. Loss of productivity
    vii. Other, please specify (free form text box)
m. Are you a pediatrician seeking payment based on 20% of your practice attributable to Medicaid? (select one) Yes or No
n. To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (needy individuals for those practicing predominantly in an FQHC or RHC). This calculation can be made at the individual provider level,

or at the clinic level. Are you attesting to patient volume based on a clinic-level calculation? (select one) Yes or No
    i. If yes, indicate the tax id and NPI of the clinic
o. To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (needy individuals for those practicing predominantly in an FQHC or RHC). Provide the beginning and end dates for the 90-day period you are claiming to prove patient volume requirements
p. Provide the total number of patient encounters for the specified 90 day reporting period
q. Provide the NPI and tax id under which you bill Medicaid
r. Are any of your Medicaid patients covered by another state's Medicaid program? If so, indicate which states.
s. Are you a Medicaid managed care provider? (i.e., see patients covered by Magellan or MediPASS?) (select one) Yes or No
    i. If yes, are you claiming Medicaid patients from your panel who you have seen in the past year, but not in the designated 90-day period, in your Medicaid patient percentage calculation? (select one) Yes or No
t. Do you see patients in more than one location?
    i. If yes, did at least 50% of your patient encounters during the EHR reporting period occur at a practice/location or practices/locations equipped with certified EHR?
    ii. Provide the addresses of each location where you see patients, and indicate the percentage of your practice at each location and whether those locations are equipped with certified EHR technology.
u. What is the verifiable data source you are using to calculate patient volume?
v. Do you practice predominately in an FQHC or RHC? "Yes or No"
    i. If yes, are 30% of your encounters for needy individuals?
    ii. Provide the number and percentage of patients falling into the following categories during the 90-day period:
        1. Iowa Medicaid
        2. other state's Medicaid (indicate the State)
        3. ***hawk-i***
        4. Patients receiving uncompensated care
        5. Patients receiving care at no cost or reduced cost based on a sliding scale determined by the individual's ability to pay

II. Eligible Hospitals

a. I represent an acute care hospital
b. My hospital's CCN is
c. My average patient length of stay is less than 25 days
d. My average patient length of stay is
e. I have adopted, implemented or upgraded to certified electronic health record (EHR) technology. 1) Adopted 2) Implemented 3) Upgraded
f. The certification number of my certified EHR is ___
g. To be eligible for the incentive, 10% of your patient encounters (ED and inpatient) over a consecutive 90-day period in the previous federal fiscal year must be attributable to Medicaid. Indicate which 90-day period you are using.
h. Indicate the total number of patient encounters for the specified 90 day reporting period
i. Are any of your Medicaid patients covered by another state's Medicaid program? If so, indicate which states.
j. What is the verifiable data source you are using to calculate patient volume?
k. To determine the average annual growth rate, using the 3 previous years Medicare cost reports, worksheet s-3, Part 1, line 23, column 15 Enter the following:
    i. Past FY -3
    ii. Past FY -2
    iii. Past FY -1
    iv. Past FY
l. Using your most recent Medicare cost report please enter the following information :
    i. Total Medicaid Days w/s S-3 part I, col. 5, SUM of lines 1, 6-10
    ii. Total Medicaid HMO days w/s S-3 Part I, col. 5, line 2
    iii. Total Hospital Charges w/s C part I, col. 8, line 101
    iv. Other uncompensated care charges w/s S-10 line 30 (excludes bad debt)
    v. Total Hospital Days w/s S-3 part 1, col. 6, lines 1, 6-10

III. Attestation

1. By clicking in the following box, you certify and agree to the following:
2. The foregoing information provided in this application is true, accurate and complete.

3. This Agreement is supplementary to the usual provider agreement entered into for participation in the Iowa Medical Assistance Program and all provisions of that agreement shall remain in full force and effect.
4. The Medicaid EHR incentive payments submitted under this National Provider Identifier (NPI) are from Federal funds, and that any falsification or concealment of material fact may be prosecuted under Federal and State laws.
5. You will maintain documentation in support of your qualifications to receive the funds for a minimum period of six years:
6. In the event the IME asks for additional information or proof on any of the information submitted as part of this application, you will cooperate in supplying any information necessary for any audit.
7. The IME will pursue repayment in all instances of improper or duplicate payment, regardless of whether there was an assignment of the payment to another entity.

IV. Definitions:

1. So led: An FQHC/RHC is "so led" by a PA when:
    i. A PA is the primary provider in a clinic
    ii. A PA is a clinical or medical director at a clinical site of practice; or
    iii. A PA is an owner of a RHC

b. Hospital-based: An eligible professional is considered to be "hospital-based" when the EP provides substantially all of his or her professional services in a hospital setting. "Substantially all" means that 90 percent or more of the services are performed in the hospital setting (patients seen in an inpatient or emergency department setting).

c. A/I/U: Adopt, implement, upgrade. Eligible professionals and eligible hospitals who meet minimum patient thresholds qualify for the first year Medicaid incentive payment by demonstrating they have adopted, implemented or upgraded to certified EHR technology.
    i. Adopt: Acquired and installed. E.g., Evidence of acquisition, installation.
    ii. Implement: Commenced utilization E.g., staff training, data entry of patient demographic information into EHR, data use agreements.
    iii. Upgrade: Version 2.0, expanded functionality E.g., ONC EHR certification.

d. Needy individuals: In determining the minimum patient volume for EPs practicing predominately in an FQHC or RHC, EPs may count needy individuals in the numerator.

i. Needy individuals are those patients who are:
ii. Covered by Medicaid or ***hawk-i***
iii. Receiving uncompensated care by the provider
iv. Furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay

b. Practices predominately: An EP practices predominately when the FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year
c. Patient encounter: A patient encounter for an EP is defined as:
   i. Services rendered on any one day to an individual where Medicaid or a Medicaid 1115 grant paid for part or all of the service; or
   ii. Services rendered on any one day to an individual where Medicaid or a Medicaid 1115 grant paid all or part of the premiums, copayments and/or cost sharing.
d. Hospital encounters: For purposes of calculating hospital patient volume, the following are to be considered Medicaid encounters:
   i. Services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service;
   ii. Services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing;
   iii. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or
   iv. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or costsharing.

PA Addendum

Additional Terms and Conditions for Physician Assistants
Practicing in an FQHC or RHC that is so led by a Physician Assistant

This Agreement is between the State of Iowa, Department of Human Services, (the "Department") and the Provider (the "Provider"). The operations management responsibility for the Iowa Medicaid Program is through the Iowa Medicaid Enterprise (the "IME").

Section 1. Provider Agrees to:

Adhere to professional standards and levels of service as set forth in all applicable local, State and Federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by the Department relating to the Provider's performance under this Agreement.

I. Abide, to the extent required, by the provisions of:

   a. Title VI of the Civil Rights Act of 1964 as amended (42 U.S.C. § 2000e), which prohibits discrimination against any employee or applicant for employment or an applicant or member of services, on the basis of race, religion, color, national origin, age or sex;
   b. Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794) as well as the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and associated regulations found at 28 C.F.R. §§ 36.101 through 36.999, which prohibit discrimination against disabled persons.
   c. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations found at 45 C.F.R. parts 160 and 164, and all laws protecting the confidentiality of patient information.

II. Comply with applicable Federal, State and local laws, regulations, administrative rules, and executive orders, including without limitation, all laws applicable to the prevention of discrimination in employment, and business permits and licenses that may be required.

III. Comply with all applicable Federal and State laws, administrative rules and written policies of the Iowa Medicaid program, including but not limited to Title XIX of the Social Security Act (as amended), the Code of Federal Regulations, the provisions of the Code of Iowa and administrative rules of the Iowa Department of Human Services and written Department policies, including but not limited to policies contained in the Iowa Medicaid

Provider Manual, and the terms of this Agreement. This section neither creates nor negates due process rights of either party.

IV. Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. Provider agrees to check the HHS-OIG website (http://exclusions.oig.hhs.gov/ or http://www.oig.hhs.gov/fraud/exclusions.asp) by the name of any individual or entity for their exclusion status before the provider hires or enters into any contractual relationship with the person or entity. In addition, Provider agrees to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Provider must report to the IME any exclusion.

V. The Provider shall maintain books, records and documents which sufficiently and properly document and calculate all charges billed to the Department throughout the term of this Agreement for a period of at least six (6) years following the date of final payment or completion of any required audit. Records to be maintained include both financial records and service records. The Provider shall permit the Auditor of the State of Iowa or any authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records or other records of the Provider relating to orders, invoices or payments or any other documentation or materials pertaining to this Agreement, wherever such records may be located. The Provider shall not impose a charge for audit or examination of the Provider's books and records.

VI. Choice of Law and Forum. The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Agreement without regard to the choice of law provisions of Iowa law. In the event of any proceeding of a quasi-judicial or judicial nature is commenced in connection with this Agreement, the proceeding shall be brought and maintained in Polk County District Court for the State of Iowa, Des Moines, Iowa or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Department or the State of Iowa.

Appendix G - HIE Participation Form Received by Iowa E-Health

The following table summarizes the number of providers who have completed an HIE participation interest form.

Which of the following best describes your organization or facility?	Response Percent	Response Count
Health System	8.0%	7
Hospital	14.8%	13
Clinic - Primary Care	22.7%	20
Clinic - Specialty	19.3%	17
Lab	4.5%	4
Pharmacy	9.1%	8
Home Health	10.2%	9
Long Term Care	21.6%	19
Radiology	3.4%	3
Other (please specify)	19.3%	17

Appendix H - Meaningful Use EP Questions

EP

Meaningful Use Core Measures

1. Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
    a. Measure: More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
    b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
        i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
        ii. This data was extracted only from patient records maintained using certified EHR technology
    c. Exclusion – based on all patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, complete the following information:
                a. Numerator = the number of patients in the denominator that have at least one medication order entered using CPOE
                b. Denominator = the number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
2. Objective: Implement drug-drug and drug-allergy interaction checks
    a. Measure: The EP has enabled this functionality for the entire EHR reporting period.
    b. Have you enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?
        i. Yes
        ii. No
3. Objective: Maintain an up-to-date problem list of current and active diagnoses.

a. Measure: More than 80% of all unique patients seen by the EP have at least one entity or an indication that no problems are known for the patient recorded as structured data.
b. Numerator = Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
c. Denominator = Number of unique patients seen by the EP during the EHR reporting period.

4. Generate and transmit permissible prescriptions electronically (eRx)
    a. Measure: more than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
    b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
        i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
        ii. This data was extracted only from patient records maintained using certified EHR technology
    c. Exclusion – based on all patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, complete the following information:
                a. Numerator = the number of prescriptions in the denominator generated and transmitted electronically.
                b. Denominator = the number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
5. Objective: Maintain active medication list
    a. More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
    b. Numerator = Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
    c. Denominator = Number of unique patients seen by the EP during the EHR reporting period.
6. Objective: Maintain active medication allergy list.

a. Measure: More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
b. Numerator = Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
c. Denominator = Number of unique patients seen by the EP during the EHR reporting period.

7. Objective: Record all of the following demographics: Preferred language, gender, race, ethnicity, date of birth
    a. Measure: More than 50% of all unique patients seen by the EP have demographics recorded as structured data.
    b. Numerator = Number of unique patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.
    c. Denominator = Number of unique patients seen by the EP during the EHR reporting period.
8. Objective: Record and chart changes in vital signs: height, weight, blood pressure, calculate and display body mass index (BMI), plot and display growth charts for children 2-20 years, including BMI.
    a. Measure: More than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data.
    b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
        i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
        ii. This data was extracted only from patient records maintained using certified EHR technology
    c. Exclusion 1 – based on all patient records: An EP who sees no patients 2 years or older would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, Exclusion 2 – based on all patient records: An EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
                a. Yes

b. No
2. If no selected, complete the following information:
    a. Numerator = the number of patients in the denominator who have at least one entry of their height, weight, and blood pressure are recorded as structured data.
    b. Denominator = the number of unique patients age 2 and over seen by the EP during the EHR reporting period.

9. Objective: Record smoking status for patients 13 years old or older.
    a. Measure: more than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
    b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
        i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
        ii. This data was extracted only from patient records maintained using certified EHR technology
    c. Exclusion – based on all patient records: An EP who sees no patients 13 years or older would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, complete the following information:
                a. Numerator = the number of patients in the denominator with smoking status recorded as structured data.
                b. Denominator = the number of unique patients age 13 or older seen by the EP during the EHR reporting period.
10. Objective: Report ambulatory clinical quality measures to CMS.
    a. Measure: Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.
    b. I will submit clinical quality measures:
        i. Yes
        ii. No
11. Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.

a. Measure: Implement one clinical decision support rule.
b. Have you implemented one clinical decision support rule relevant to specialty of high clinical priority along with the ability to track compliance to that rule?
    i. Yes
    ii. No

12. Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.
    a. Measure: more than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.
    b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
        i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
        ii. This data was extracted only from patient records maintained using certified EHR technology
    c. Exclusion – based on all patient records: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, complete the following information:
                a. Numerator = the number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.
                b. Denominator = the number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

13. Objective: Provide clinical summaries for patients for each office visit.
    a. Measure: Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.
    b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
ii. This data was extracted only from patient records maintained using certified EHR technology

c. Exclusion – based on all patient records: Any EP who has no office visits during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
    i. Yes
    ii. No
        1. If no selected, complete the following information:
            a. Numerator = the number of office visits in the denominator for which a clinical summary is provided within three business days.
            b. Denominator = the number of office visits for the EP during the EHR reporting period.

14. Objective: Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically.
    a. Measure: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
    b. Have you performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information?
        i. Yes
        ii. No
15. Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
    a. Measure: Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
    b. Have you conducted or reviewed a security risk analysis per 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies as part of its risk management process?
        i. Yes
        ii. No

Meaningful Use Menu Measures

EPs must report on a total of five meaningful use menu measures. At least one of the five measures must be from public

health measures. Should the EP be able to successfully meet only one of these public health menu measures, the EP must select and report on that measure to CMS. Having met one public health menu measure, the EP must then select any other four measures from the Meaningful Use Menu Measures. In selecting the remaining four measures, the EP may select any combination of the remaining public health menu measure or from the additional Meaningful Use Menu measures in the list below.

If an EP meets the criteria for and can claim an exclusion for both of the public health measure, the EP must still select one public health menu measure and attest that the EP qualifies for the exclusion. The EP must then select any other four measures from the menu measures, which can be any combination of the remaining public health menu measure or form the addition meaningful use menu measures in the list below. CMS encourages EPs to select menu measures that are relevant to their scope of practice and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they quality or if there are no remaining menu measures that re reluctant to their scope of practice.

You must submit at least one Meaningful Use Menu Measure from the public health list even if an exclusion applies to both.

1. Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.
    a. Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)
    a. Exclusion 1 – based on all patient records: An EP who does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, Exclusion 2 – based on all patient records: If there is no immunization registry that has the capacity to receive the information electronically, an EP would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
                a. Yes

b. No
    i. If no selected, did you perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful?
        1. Yes
        2. No

2. Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.
    a. Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).
    b. Exclusion 1 – based on all patient records: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, then the EP is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            2. If no selected, Exclusion 2 – based on all patient records: If there is no public health agency that has the capacity to receive the information electronically, then the EP is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
                a. Yes
                b. No
                    i. If no selected, did you perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful?
                        1. Yes
                        2. No

You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measure Objectives have been selected, even if an Exclusion applies to all of the menu measure objectives that are selected (total of five includes

the public health menu measure objectives):

2. Objective: Implement drug formulary checks.
    a. Measure: The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
    b. Exclusion – based on all patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, have you enabled the drug formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period?
3. Objective: Incorporate clinical lab-test results into EHR as structured data.
    a. Measure: More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
    b. Exclusion – based on all patient records: An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
        i. Yes
        ii. No
            1. If no selected, complete the following information:
                a. Numerator = the number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
                b. Denominator = the number of lab test ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
4. Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.
    a. Measure: Generate at least one report listing patients of the EP with a specific condition.
    b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
ii. This data was extracted only from patient records maintained using certified EHR technology

c. Have you generated at least one report listing your patients with a specific condition?
i. Yes
ii. No

5. Objective: Send reminders to patients per patient preference for preventive/follow up care.
a. Measure: more than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
ii. This data was extracted only from patient records maintained using certified EHR technology
c. Exclusion – based on all patient records: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
i. Yes
ii. No
1. If no selected, complete the following information:
a. Numerator = the number of patients in the denominator who were sent the appropriate reminder.
b. Denominator = the number of unique patients 65 years old or older or 5 years old or younger.

6. Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP.
a. Measure: At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EPs discretion to withhold certain information.
b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
ii. This data was extracted only from patient records maintained using certified EHR technology

c. Exclusion – based on all patient records: Any EP who neither orders nor creates lab tests or information that would be contained in the problem list, medication list, or medication allergy list during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
   i. Yes
   ii. No
      1. If no selected, complete the following information:
         a. Numerator = the number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online)
         b. Denominator = the number of unique patients seen by the EP during the EHR reporting period.

7. Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
   a. Measure: More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.
   b. Complete the following information:
      a. Numerator = the number of patients in the denominator who are provided patient education specific resources
      b. Denominator = the number of unique patients seen by the EP during the EHR reporting period.
8. Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
   a. Measure: The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.
   b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
      i. This data was extracted from ALL patient records not just those maintained using certified EHR technology

ii. This data was extracted only from patient records maintained using certified EHR technology

c. Exclusion – based on all patient records: An EP who was not on the receiving end of any transition of care during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
   i. Yes
   ii. No
      1. If no selected, complete the following information:
         a. Numerator = the number of transitions of care in the denominator where medication reconciliation was performed.
         b. Denominator = the number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

9. Objective: The EP who transitions his/her patient to another setting of care or provider of care or refers his/her patient to another provider of care should provide summary of care record for each transition of care or referral.
   a. Measure: The EP who transitions or refer his/her patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.
   b. Patient records: please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
      i. This data was extracted from ALL patient records not just those maintained using certified EHR technology
      ii. This data was extracted only from patient records maintained using certified EHR technology
   c. Exclusion – based on all patient records: An EP who does transfer a patient to another setting or refer a patient to another provider during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
      i. Yes
      ii. No
         1. If no selected, complete the following information:
            a. Numerator = the number of transitions of care and referrals in the denominator where a summary of care record was provided.
            b. Denominator = the number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

Error messages – please select at least one public health measure
Please select a total of five MU menu measure objectives (includes MU menu measures from the public health list).

Core Clinical Quality Measures

Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an alternate core clinical quality measure must also be submitted.

1. NQF 0013
    a. Title: Hypertension, Blood Pressure Management
    b. Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
    c. Denominator:
    d. Numerator:
2. NQF 0028/PQRI 114
    a. Title: Preventive Care and Screening Measure Pair
        i. Tobacco use assessment
            1. Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months.
                a. Denominator:
                b. Numerator:
        ii. Tobacco cessation intervention
            1. Description: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
                a. Denominator:
                b. Numerator:
3. NQF 0421/PQRI 128
    a. Title: Adult weight screening and follow-up
    b. Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

c. Complete the following information:

Population Criteria 1	Denominator	Numerator 1	Exclusion
Population Criteria 2	Denominator	Numerator 2	Exclusion

Alternate Clinical Quality Measures

Instructions: You have entered a denominator of zero for one of your Core Clinical Quality Measures. You must submit one Alternate Clinical Quality Measure.

Please select one Alternate Clinical Quality Measure from the list below.

Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Measure#	Title	Description	Selection
NQF 0024	Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	
NQF 0041 / PQRS 110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	
NQF 0038	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and	

		rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	

Instructions: You have entered a denominator of zero for two of your Core Clinical Quality Measures. You must submit two Alternate Clinical Quality Measures.
Please select two Alternate Clinical Quality Measures from the list below.
Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Measure#	Title	Description	Selection
NQF 0024	Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	
NQF 0041 / PQRS 110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	

	Years Old		
NQF 0038	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	

Instructions: You have entered a denominator of zero for all of your Core Clinical Quality Measures. You must submit all of the Alternate Clinical Quality Measures. Please select all of the Alternate Clinical Quality Measures from the list below. Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Measure#	Title	Description	Selection
NQF 0024	Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	
NQF 0041 / PQRS 110	Preventive Care and Screening:	Percentage of patients aged 50 years and older who received an influenza	

	Influenza Immunization for Patients ≥ 50 Years Old	immunization during the flu season (September through February).	
NQF 0038	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	

NQF 0024

Title: Weight Assessment and Counseling for Children and Adolescents

Description: Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Complete the following information:

Population Criteria 1	Denominator:	Numerator 1:
	Denominator:	Numerator 2:
	Denominator:	Numerator 3:
Population Criteria 2	Denominator:	Numerator 1:
	Denominator:	Numerator 2:
	Denominator:	Numerator 3:
Population Criteria 3	Denominator:	Numerator 1:

	Denominator:	Numerator 2:
	Denominator:	Numerator 3:

NQF 0041 / PQRI 110

Title: Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old

Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0038

Title: Childhood Immunization Status

Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four
pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Complete the following information:

Denominator:	Numerator 1:	Denominator:	Numerator 7:
Denominator:	Numerator 2:	Denominator:	Numerator 8:
Denominator:	Numerator 3:	Denominator:	Numerator 9:
Denominator:	Numerator 4:	Denominator:	Numerator 10:
Denominator:	Numerator 5:	Denominator:	Numerator 11:
Denominator:	Numerator 6:	Denominator:	Numerator 12:

Additional Clinical Quality Measures

Instructions: Select three Additional Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), and exclusion(s), if applicable, for all three Additional Clinical Quality Measures after you select the CONTINUE button below.

Measure#	Title	Description	Selection
NQF	Asthma Assessment	Percentage of patients aged 5	

0001 / PQRI 64		through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	
NQF 0002 / PQRI 66	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection	

		during the first or second prenatal care visit.	
NQF 0014	Prenatal Care: Anti-D Immune Globulin	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.	
NQF 0018	Controlling High Blood Pressure	The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.	
NQF 0027 / PQRI 115	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	
NQF 0031 / PQRI 112	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	

NQF 0032	Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	
NQF 0033	Chlamydia Screening for Women	Percentage of women 15- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	
NQF 0034 / PQRI 113	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	
NQF 0036	Use of Appropriate Medications for Asthma	Percentage of patients 5 - 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).	
NQF 0043 / PQRI 111	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	
NQF 0047 / PQRI 53	Asthma Pharmacologic Therapy	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an	

		acceptable alternative treatment.	
NQF 0052	Low Back Pain: Use of Imaging Studies	Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	
NQF 0055 / PQRI 117	Diabetes: Eye Exam	Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.	
NQF 0056 / PQRI 163	Diabetes: Foot Exam	The percentage of patients aged 18 - 75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).	
NQF 0059 / PQRI 1	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.	
NQF 0061 / PQRI 3	Diabetes: Blood Pressure Management	Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.	
NQF 0062 / PQRI 119	Diabetes: Urine Screening	Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.	

NQF 0064 / PQRI 2	Diabetes Low Density Lipoprotein (LDL) Management and Control	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL).	
NQF 0067 / PQRI 6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	
NQF 0068 / PQRI 204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.	
NQF 0070 / PQRI 7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	

	Myocardial Infarction (MI)		
NQF 0073 / PQRI 201	Ischemic Vascular Disease (IVD): Blood Pressure Management	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).	
NQF 0074 / PQRI 197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).	
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November1 of the	

		year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.	
NQF 0081 / PQRI 5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	
NQF 0083 / PQRI 8	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.	
NQF 0084 / PQRI 200	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	
NQF 0086 /	Primary Open Angle Glaucoma (POAG):	Percentage of patients aged 18 years and older with a diagnosis	

PQRI 12	Optic Nerve Evaluation	of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.	
NQF 0088 / PQRI 18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	
NQF 0089 / PQRI 19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	
NQF 0105 / PQRI 9	Anti-depressant medication management: (a) Effective Acute Phase	Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with	

	Treatment, (b) Effective Continuation Phase Treatment	antidepressant medication, and who remained on an antidepressant medication treatment.	
NQF 0385 / PQRI 72	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.	
NQF 0387 / PQRI 71	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	
NQF 0389 / PQRI 102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging LowRisk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	

NQF 0575	Diabetes: Hemoglobin A1c Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.	

NQF 0059 / PQRI 1

Title: Diabetes: Hemoglobin A1c Poor Control

Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.

Complete the following information:

Denominator:	Numerator:	Exclusion

NQF 0064 / PQRI 2

Title: Diabetes: Low Density Lipoprotein (LDL) Management and Control

Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL).

Complete the following information:

Denominator:	Numerator1:	Exclusion
Denominator:	Numerator2:	

NQF 0061 / PQRI 3

Title: Diabetes: Blood Pressure Management

Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.

Complete the following information:

Denominator:	Numerator:	Exclusion

NQF 0081 / PQRI 5

Title: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.

Complete the following information:

Denominator:	Numerator:	Exclusion

NQF0070 / PQRI 7
Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed betablocker therapy.
Complete the following information:

Denominator:	Numerator:	Exclusion

NQF0043 / PQRI 111
Title: Pneumonia Vaccination Status for Older Adults
Description: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
Complete the following information:

Denominator:	Numerator:

NQF 0031 / PQRI 112
Title: Breast Cancer Screening
Description: Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
Complete the following information:

Denominator:	Numerator:

NQF 0034 / PQRI 113
Title: Colorectal Cancer Screening
Description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0067 / PQRI 6
Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0083 / PQRI 8

Title: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0105

Title: Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment

Description: Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Complete the following information:

Denominator:	Numerator 1:
Denominator:	Numerator 2:

NQF 0086 / PQRI 12

Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0088 / PQRI 18

Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0089 / PQRI 19

Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0047 / PQRI 53

Title: Asthma Pharmacologic Therapy

Description: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0002 / PQRI 66

Title: Appropriate Testing for Children with Pharyngitis

Description: Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Complete the following information:

Denominator:	Numerator :

NQF 0387 / PQRI 71

Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer

Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0385 / PQRI 72

Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0389 / PQRI 102

Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0027 / PQRI 115

Title: Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies

Description: Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

Complete the following information:

Denominator:	Numerator 1:
Denominator:	Numerator 2:

NQF 0055 / PQRI 117

Title: Diabetes: Eye Exam

Description: Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0062 / PQRI 119
Title: Diabetes: Urine Screening
Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0056 / PQRI 163
Title: Diabetes: Foot Exam
Description: The percentage of patients aged 18 - 75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).
Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0074 / PQRI 197
Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0084 / PQRI 200
Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
Description: Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.
Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0073 / PQRI 201
Title: Ischemic Vascular Disease (IVD): Blood Pressure Management

Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).
Complete the following information:

Denominator:	Numerator:

NQF 0068 / PQRI 204

Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the
measurement year.
Complete the following information:

Denominator:	Numerator:

NQF 0004

Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
Description: Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Complete the following information:

Population Criteria 1	Denominator:	Numerator 1:
	Denominator:	Numerator 2:
Population Criteria 2	Denominator:	Numerator 1:
	Denominator:	Numerator 2:
Population Criteria 3	Denominator:	Numerator 1:

	Denominator:	Numerator 2:

NQF 0001 / PQRI 64

Title: Asthma Assessment

Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

Complete the following information:

Denominator:	Numerator:

NQF 0012

Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)

Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0014

Title: Prenatal Care: Anti-D Immune Globulin

Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.

Complete the following information:

Denominator:	Numerator:	Exclusion:

NQF 0018

Title: Controlling High Blood Pressure

Description: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

Complete the following information:

Denominator:	Numerator:

NQF 0032

Title: Cervical Cancer Screening
Description: Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.
Complete the following information:

Denominator:	Numerator:

NQF 0033
Title: Chlamydia Screening for Women
Description: Percentage of women 15- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Complete the following information:

Population Criteria 1	Denominator:	Numerator:	Exclusion:
Population Criteria 2	Denominator:	Numerator:	Exclusion:
Population Criteria 3	Denominator:	Numerator:	Exclusion:

NQF 0036
Title: Use of Appropriate Medications for Asthma
Description: Percentage of patients 5 - 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
Complete the following information:

Population Criteria 1	Denominator:	Numerator:	Exclusion:
Population Criteria 2	Denominator:	Numerator:	Exclusion:
Population Criteria 3	Denominator:	Numerator:	Exclusion:

NQF 0052
Title: Low Back Pain: Use of Imaging Studies

Description: Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray,MRI, CT scan) within 28 days of diagnosis.
Complete the following information:

Denominator:	Numerator:

NQF 0075

Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDLC<100 mg/dL.
Complete the following information:

Denominator:	Numerator1:
Denominator:	Numerator 2:

NQF 0575

Title: Diabetes: Hemoglobin A1c Control (<8.0%)
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.
Complete the following information:

Denominator:	Numerator:	Exclusion:

Summary of Measures

Please select the desired measure link below to review the details of your attestation. This is your last chance to view/edit the information you have entered before you attest. Please review your information as you will be unable to edit your information after you attest.

Meaningful Use Core Measures List Table
Meaningful Use Menu Measures List Table
Clinical Quality Measures List Table

<<tables display all answers with option to edit>>